

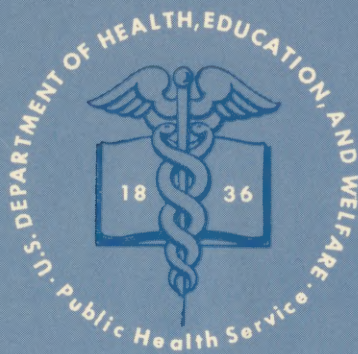
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Massachusetts. Special Commission on Mental Diseases

The Commonwealth of Massachusetts

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REPORT

OF THE

SPECIAL COMMISSION ESTABLISHED TO STUDY THE
WHOLE MATTER OF THE MENTALLY DISEASED
IN THEIR RELATION TO THE COMMON-
WEALTH, INCLUDING ALL PHASES
OF WORK OF THE DEPART-
MENT OF MENTAL
DISEASES

UNDER CHAPTER 1 OF THE RESOLVES OF 1938

MARCH 1, 1939

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The Commonwealth of Massachusetts

STATE HOUSE, BOSTON, MASS., March 1, 1938.

To the General Court of Massachusetts.

The Special Commission, created originally under chapter 7, Resolves of 1937, and subsequently revived under chapter 1, Resolves of 1938, to investigate the whole matter of the mentally diseased in their relation to the Commonwealth, including all phases of the Department of Mental Diseases, respectfully submits the following report as the expression of the findings of the Commission.

JOHN F. PERKINS,

Chairman.

ERLAND F. FISH,

Vice-Chairman.

JOSEPH W. MONAHAN.

THOMAS P. DILLON.

JOHN M. GRAY.

W. A. BROWN.

FRANCIS X. COYNE.

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The Commonwealth of Massachusetts

REPORT OF THE SPECIAL COMMISSION ESTABLISHED TO STUDY THE WHOLE MATTER OF THE MENTALLY DISEASED IN THEIR RELATION TO THE COMMONWEALTH, INCLUDING ALL PHASES OF WORK OF THE DEPARTMENT OF MENTAL DISEASES.

SECTION I. ORGANIZATION OF THE COMMISSION.

When the Special Commission on Mental Diseases, created by chapter 7 of the Resolves of 1937, filed its report with the Legislature on December 17, 1937, it recommended that the Special Commission, or a similar group, be authorized to continue the investigation recommended by the Governor in his inaugural message to the General Court on January 7, 1937. The Commission desired to continue its study relative to the formulation of a ten-year building program for the Department of Mental Diseases, to review the organizational set-up of the Department and the hospitals under its supervision, and to inquire into certain policies of the Department and the hospitals.

This recommendation was included by the Governor in his message to the Legislature on January 5, 1938, which follows:

By virtue of the authority of this Legislature, I was empowered to appoint an unpaid Special Commission to investigate the problem of the mentally ill. The Commonwealth has been fortunate in obtaining for this service men of outstanding character and ability who have

labored tirelessly in most unusual harmony since assuming office in April, 1937. Last month the Commission submitted a very comprehensive report which suggests a constructive plan for the reorganization of the Department of Mental Diseases. I recommend that appropriate legislation be enacted to include the salient features of this report. I recommend further that you authorize me to reappoint the Commission for another year in order that it may complete the work which it has so creditably begun.

The Commission was recreated and empowered to continue its study under chapter 1 of the Resolves of 1938, which was signed by the Governor on January 31, 1938. The resolve follows:

Resolved, That the unpaid special commission, established by chapter seven of the resolves of nineteen hundred and thirty-seven, is hereby revived and continued for the purpose of continuing its investigation and study of the whole matter of the mentally diseased in their relation to the commonwealth, including all phases of the work of the department of mental diseases. Said commission shall hold hearings, may require of the department of mental diseases and such other departments and such commissions or officers of the commonwealth as have or can obtain information in relation to the subject matter of this resolve such assistance as may be helpful in the course of its investigation and study, and may require by summons the attendance and testimony of witnesses and the production of such books and papers as relate to the matter under investigation. Said commission may travel within and outside the commonwealth, and it shall make a supplementary report to the general court of the results of its investigation and study hereunder and its recommendations, if any, together with drafts of legislation necessary to carry said recommendations into effect, by filing the same with the clerk of the house of representatives on or before the first Wednesday of December in the current year. For the purposes of this resolve, said commission may expend such sums as may hereafter be appropriated therefor, in addition to the unexpended balance of the amount appropriated by item thirty-six b of chapter four hundred and thirty-four of the acts of nineteen hundred and thirty-seven, and said balance is hereby made available for payment of expenses incurred by said commission.

The first meeting of the Commission was held February 4, 1938, at the State House. Those attending were Judge John F. Perkins of Milton, Chairman, Maj.-Gen. Erland F. Fish of Brookline, Vice-Chairman, Dr. L. Vernon Briggs of Boston, the Rev. Otis F. Kelly of

Brighton, Judge Joseph W. Monahan of Belmont, Representative Thomas P. Dillon of Cambridge, and Mr. John M. Gray of Salem. William J. Griffin, Secretary, and Margaret R. Cotter, Stenographer, were reappointed.

On October 5 Father Kelly resigned his position with the Commission, and on October 11 Dr. Briggs also resigned. To fill these vacancies the Governor, acting under authority of chapter 7, Resolves of 1937, appointed Representative Francis X. Coyne of Boston and Representative William A. Brown of North Abington. The new members served with the Commission until it went out of existence.

SECTION II. CHRONOLOGY OF THE COMMISSION.

The Special Commission on Mental Diseases came into being in May, 1937, when the Department of Mental Diseases and certain hospitals were prominent in the public mind because of charges of neglect of patients, inadequate and poorly prepared food, insufficient and badly furnished buildings, low morale among the Department and hospital personnel, and waste and extravagance in the expenditure of public moneys.

Governor Charles F. Hurley, in his 1937 inaugural message, had noted that there had been requests by the Department of Mental Diseases, for itself and the state schools and hospitals, for a sum totalling \$28,000,000, or \$17,000,000 in excess of the largest budget the Department had ever been given. While sympathetic toward any program which would better the welfare of the patients and the hospital personnel, nevertheless, he believed that the program advanced by the Department should be closely scrutinized by a special commission.

In addition, certain events at the Boston State Hospital had focussed public attention on that institution, with subsequent publicity which alarmed the public and convinced many that there was something radically wrong with the administration of the hospital.

At the first meeting of the Commission, the chairman emphasized the necessity of obtaining first-hand information as to conditions in the hospitals so that, if the administration of the hospitals had not fallen down, the public could be reassured on this point, or, if there was something wrong, corrective measures could be applied.

Members of the Commission visited the hospitals personally and conferred with the staff and personnel, as well as patients. Thorough examination of the food, the accommodations and the treatment given the patients was

made. Inspection of the buildings took considerable time. Individually, the superintendents were questioned about their specific problems. The Commission held many hearings attended by representatives of the Department of Mental Diseases and other state departments, as well as representatives of the agencies which come in contact with the Department. As a result of this study we were convinced that a reorganization of the central department was needed, and recommended a reorganization bill which was amended and became law. Unfortunately it did not become operative until October 5, 1938.

The Commission came to the conclusion that a personal inspection of the hospitals, as well as consultation with competent authorities, would satisfy the demand for first-hand information. At a meeting held at the State House in June, 1937, we asked the superintendents to give their views on various matters, and appointed groups of them to committees to study various subjects and report their findings and recommendations. The Commission found these studies helpful. A list of the superintendents and the committees to which they were assigned will be found in Appendix 19.

An important by-product of the meeting of the superintendents and the Commission, and the inspection of the hospitals by the Commission, was the noticeable improvement in the various hospitals. Apparently the interest shown by the Commission in their work, and the opportunity afforded them to assist the Commission with their technical knowledge, proved a stimulus which produced beneficial results all around. This improvement, we are pleased to note, continued throughout the life of the Commission.

Among the matters studied was that of the food budget, and the Commission became convinced that for the existing complicated system there should be substituted a more simple system based on the number of persons to be fed. This was done, and a survey shows that food costs, in money value, dropped in 1938.

When the Commission was recreated on February 1, 1938, plans were laid for a thorough professional inspection of the hospitals. We obtained the assistance of Dr. Samuel W. Hamilton, director of the Mental Hospital Survey Committee (a subsidiary of the National Committee for Mental Hygiene of New York), a recognized expert in this specialty, and commissioned him to make a study of each of the hospitals and schools. With him were Dr. Morgan B. Hodskins, superintendent of the Monson State Hospital, the Rev. Otis F. Kelly and Dr. Grover A. Kempf, associate director of the Mental Hospital Survey Committee. The survey was completed late in January of this year.

During the second year of its existence the Commission members continued to visit hospitals in this State, as well as outside. Because of the pressing need for a hospital for the criminal insane the Commission visited what is considered to be the finest institution of its kind in the country, the Menard Branch (Hospital for Criminal Insane) of the Illinois State Penitentiary, located at Chester, Ill., and obtained helpful information. We were able to do this through the courtesy of Mr. A. L. Bowen, director of the Department of Public Welfare, Springfield, Ill., and Mr. Joseph E. Ragen, superintendent of prisons in Illinois.

The Commission in its studies emphasized the medical aspect of the administration of the hospitals, because during the last year reports on the audits of certain hospitals were made by State Auditor Thomas H. Buckley, while Patrick J. Moynihan, chairman of the Commission on Administration and Finance, also made a general survey into the business administration.

At the suggestion of Governor Hurley, Chairman Moynihan and Eugene M. McSweeney, Commissioner of Public Safety, made an investigation relative to the matter of sudden deaths in the hospitals. A statement issued by the Governor's office relative to this investigation and comments of the then Acting Commissioner, Dr. Clifton T. Perkins, will be found in Appendix 20.

Dr. David L. Williams was Commissioner of Mental Diseases when the Special Commission came into existence in May, 1937. Governor Hurley initiated removal proceedings shortly thereafter, and the Commissioner became ill. He did not take an active part in the administration of the Department from that time on. He did, however, appoint his assistant, Dr. Clifton T. Perkins, as Acting Commissioner on May 6, 1937, a position he retained until he was appointed Commissioner of Mental Health on October 5, 1938.

SECTION III. THE REPORT.

Throughout its existence in 1937, the Special Commission studying the whole matter of the mentally diseased in their relationship to the Commonwealth was handicapped because there was no active Commissioner of Mental Diseases with whom the Commission members could sit down in friendly fashion and discuss the affairs of this huge Department.

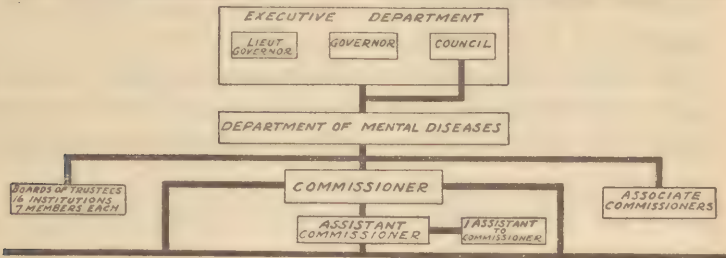
After a painstaking study, which included many visits to the hospitals, the Department, and consultation with many interested persons, the Commission came to the conclusion that the foremost matters to be taken up were the reorganization of the central department, and a study of the individual hospitals with a view to determining whether public apprehension over the administration of the hospitals was justified, and, if so, what remedial steps should be taken.

In addition, the Commission had other matters to study, including the ten-year building program, size of hospitals, disposition of the so-called criminally insane, mentally ill at Tewksbury, schools for the feeble-minded, problem of psychotic children, defective delinquents, housing of employees, food, education and research, and a study of the laws relating to the work of the Department. We have included as Appendix 1 the 1937 report submitted to the Legislature. It gives in detail the organization of the Department in 1937 (Chart A) and the organization recommended by the Commission (Chart B), as well as recommendations for eliminating the administrative duties of the trustees and the qualifications for the key executives in the Department and the hospitals. Chart C portrays the organization of the Department at the present time.

In addition, the Commission advocated a transfer to the Department of certain duties of the boards of trustees, including that of appointing or removing super-

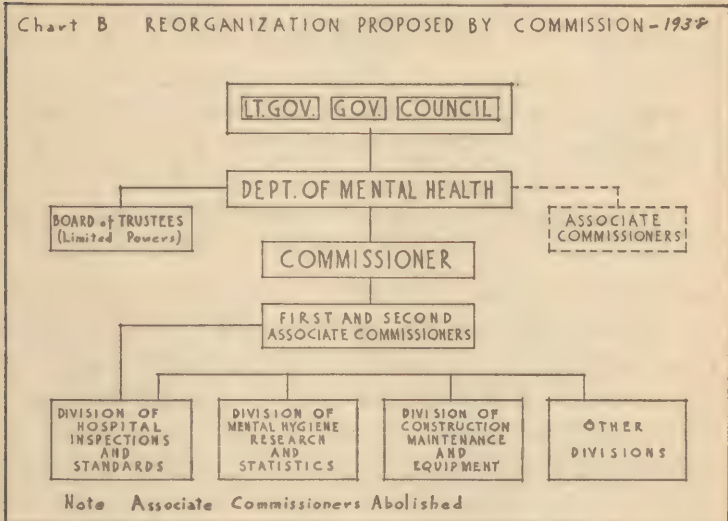
intendents. The superintendent, in turn, would appoint, subject to the Department rules, subordinate personnel. We recommended that the trustees act chiefly as a link

Chart A DEPARTMENT OF MENTAL DISEASES — 1937



between the hospital and the public, so as to relieve them of onerous administrative duties they could not adequately perform for various reasons; but we specifically reserved to them the authority to conduct investigations at any time.

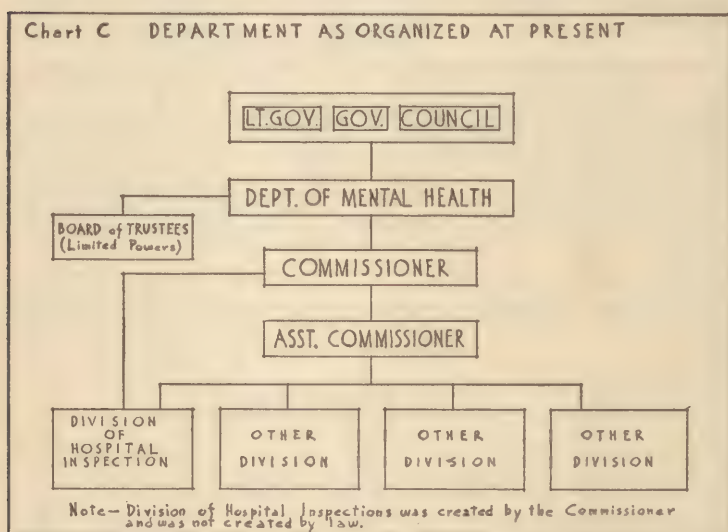
Chart B REORGANIZATION PROPOSED BY COMMISSION — 1938



Our bill was sent to the Legislature with an earnest request that it be adopted as speedily as possible, so that the Commission or a similar agency could continue to work with the co-operation of an active Commissioner and properly staffed Department.

The legislation was delayed as it moved through the legislative process. Public hearings were held before the committees on state administration and public welfare, sitting jointly, and the ways and means committee. Amendments, which changed the bill drastically in several respects, were offered in committee and in the two branches of the General Court. (See charts.)

The Governor signed the bill on June 7, 1938. During the interim between the filing of the report and the signing of the bill, the Commission's appeal for speed was



lost. No emergency preamble was attached and therefore the bill did not become law until October 5, 1938. Thus again the Commission was compelled to work without an active Commissioner during a major portion of the second year of its existence. At all times the Commission had the full co-operation of Dr. Clifton T. Perkins while he was Acting Commissioner, but, naturally, he was reluctant to initiate policies which might be disowned or changed radically by his successor.

After his appointment and confirmation, Dr. Perkins, who consulted frequently with the Commission, inaugurated a program designed to increase the supervision of the Department over the hospitals, and at the same time

not interfere, unduly, with the administration of the institutions. He has continued the same divisions, but added an inspector of hospitals, whose duty it is to check the private and public mental hospitals; has provided the business agent with needed assistants; and has in mind other policies which will, we believe, in time greatly enhance the effectiveness and efficiency of the Department.

The law reorganizing the Department, with but a single exception referred to later, has not been in effect a sufficient length of time to indicate where major changes are necessary. Whatever changes we have recommended in Appendix 10 are the recommendations of the committee of superintendents, who examined the laws relating to the Department at our request, and others which seemed desirable from the administrative viewpoint. The Legislature authorized the Senate Counsel, Mr. Fernald Hutchins, to study the laws relating to the Department, with a view to ironing out ambiguities and clarifying the law. This Commission has co-operated with Mr. Hutchins in its recommendations for clarifying the law.

In our 1937 report we stated that as a result of our investigation we had come to the conclusion that the mentally ill in Massachusetts state hospitals were receiving a type of care and treatment better than the average person in comfortable circumstances obtains when he becomes sick. The majority of the Commission were laymen, unfamiliar with the details of hospital administration and the care and treatment of the mentally ill, and were determined that a further check should be made by persons professionally qualified to do so.

We arranged, therefore, for a thorough inspection of the various institutions by an expert trained in that specialty, Dr. Samuel W. Hamilton of New York, director of the Mental Hospital Survey Committee. In this work he was assisted by Dr. Morgan B. Hodskins, superintendent of the Monson State Hospital, the Rev. Otis F. Kelly of Brighton, and Dr. Grover A. Kempf, associate director of the Mental Hospital Survey Committee.

We did not ask Dr. Hamilton specifically to inspect the business administrations of the hospitals, because the

State Auditor, Thomas H. Buckley, was then engaged in his annual audit of the hospitals, and Patrick J. Moynihan, chairman of the State Commission on Administration and Finance, at the instance of Governor Hurley, had made special studies.

A reading of Dr. Hamilton's report (Appendix 11) will convince any one that Massachusetts has held her position as a leader in the field of psychiatry. Although handicapped in many respects, the hospital superintendents have shown a commendable spirit in adhering to the high standards which have always been associated with Massachusetts mental hospitals. This thoroughly professional study amply justifies the confidence of the Commission in the hospitals, as stated in our 1937 report.

Relatives and friends of patients in the state hospitals, as well as the general public, can be assured that the standards of care and treatment provided by the state hospitals for the patients in their charge rank with the best in the country.

At our suggestion, Dr. Hamilton included in his report his conclusions and recommendations. These, of course, represent his personal opinions and are open to discussion and consideration, but we have appended them in the belief that the public should be as completely informed as possible regarding the state hospitals. It is the first time to our knowledge that a report of a complete and independent survey of the Department and all the Massachusetts mental hospitals has ever been made public.

In our 1937 report we stated that lack of time prevented the Commission from completing its study of certain subjects which properly came within the scope of the resolve, particularly in formulating a building program for the next ten years. We noted these unfinished subjects as follows:

BUILDING PROGRAM.

One of the major duties confronting the Commission was a formulation of a ten-year building program. The

Commission spent many months examining the buildings at the various state hospitals and schools. We also studied the various types of hospital construction, not only in this State but in other States.

In the hospital buildings, exclusive of feeble-minded schools and Bridgewater, the total capacity in accordance with the Department's allotment of space is 18,716. A 300-bed building under construction at Grafton will bring the total to 19,016. The total number of patients resident in the hospitals as of January 1, 1939, was 21,765. Deducting the working capacity figured by the Department from this would show a need for 3,049 beds. Our study, however, convinced us that the working capacity of the hospitals could be figured on a more liberal basis than it has been in the past, and it would be conservative to say that the total excess at the present time, after a re-allotment of space, would properly not exceed 2,700 beds.

The average increase in the resident population in the hospitals is 400 a year, but this average, we have been informed, is gradually declining. A conservative estimate for additional beds to take care of this increase for the next five years is 1,885 beds, which, added to the 2,700 beds necessary to eliminate overcrowding, makes a grand total of 4,585 beds. In our building program we have recommended a sufficient number of beds to eliminate the overcrowding and to take care of this estimated increase for the next five years.

We have in mind that by that time the Department's program of boarding out patients will have reached a peak, thus easing pressure for new beds; that means will be perfected to move out of the hospitals those custodial patients entitled to receive old age benefits now denied them because of their residence in institutions; and that the rapid advances being made in curing mentally ill patients will result in the discharge of a substantial number of patients. We have also recommended a sufficient number of beds to take care of the present overcrowding and the normal increase in the institutions for the feeble-minded.

The need for building construction is constantly changing as the needs of the hospitals and the policies of the Department vary from time to time. While we have set up our building program on a yearly basis, nevertheless, it is not a hard and fast model. Undoubtedly, certain projects may be advanced several years ahead of the time indicated in the building program, while others may be postponed.

We have tried to outline a well-rounded building program which, for a ten-year period, will provide accommodations for the present and future population of the hospitals. Each of the items has been thoroughly studied before it was placed in the program. In doing so we had to reject scores of projects submitted to us by the Department and the superintendents because, in our opinion, there was a more pressing need for the projects named in the building program.

In the last few years we have recommended the construction of buildings for the housing of superintendents, hospital officers and employees. Several of the superintendents are compelled to live in hospital buildings at the present time. By the time accommodations have been erected for the employees, we believe that these other important, but not as pressing, needs can be satisfied.

The Department has recently launched an ambitious program to board out patients in carefully selected homes. If the Department's goal of boarding out from 450 to 500 patients is reached there will be a saving of between \$1,500,000 and \$2,000,000 in capital investment for new buildings, plus the cost of maintaining them.

SIZE OF HOSPITALS.

A 2,000-bed hospital has been the traditional size for hospitals in this State, and our investigation discloses that mental hospitals range in size from 1,100-bed to 10,000-bed institutions. There are medical men who advocate the smaller size hospital because the treatment is more individual and concentrated, while others favor the larger

size hospitals because of economy in administration and maintenance. In our building program we have recommended that those hospitals which have not been built up to the 2,000-bed limit be added to until that limit is reached, with the exception of Foxborough, which, temporarily at least, should be limited to 1,700 beds.

We have not made a final recommendation on this important policy of size because the future development of the hospitals will be decided by new and as yet undetermined standards. It is a subject, however, which could well be studied by a committee of superintendents referred to elsewhere. This committee should be familiar with the changes of thought on this subject, so that the Department at all times will be thoroughly conversant with the latest opinion on this matter.

CARE OF THE SO-CALLED CRIMINALLY INSANE.

The Commission was officially represented before the ways and means committee last year and a recommendation was made that a hospital for the criminally insane be constructed on state land at Norfolk at a cost of \$1,700,000. Authority to construct this hospital was given by the Legislature (chapter 421, Acts of 1935), and only awaits an appropriation by the General Court to become a reality. We have been pleased to note that His Excellency, Governor Leverett Saltonstall, has included this recommendation in his 1939 budget message. In Appendix 4 we have given our reasons for the construction of the hospital and the transfer of the criminally insane patients to the Department of Mental Health.

MENTALLY ILL AT TEWKSBURY.

The mentally ill population at Tewksbury State Infirmary is gradually declining, as is shown in Appendix 5. No new patients have been accepted since October 10, 1931. With this policy in effect the population will fall as patients die, and the rate of decreases can be accelerated as desired by the transfer, when space is available,

of patients to institutions directly under the control of the Department of Mental Health.

SCHOOLS FOR FEEBLE-MINDED.

We wish to emphasize the importance of training the mentally deficient so that they can find their place in the community and become assets rather than liabilities. For a full discussion as to the whole problem of the mentally deficient see Appendix 6.

There are approximately 3,200 mentally deficient persons on the waiting list for entry into the feeble-minded schools. This list is kept up to date constantly by a monthly check. It has been estimated that there are approximately 90,000 feeble-minded persons throughout the State. A new school for the feeble-minded has been discussed for many years. We have recommended in our building program that no new school be built, but that the existing schools be brought up to the 2,000-bed limit, thus providing space for about 664 additional patients.

For years the complaint has been made, and the graphs included in Appendix 6 bear out the contention, that the state schools have gradually filled up with custodial cases. Accommodations have necessarily been curtailed for the trainable high-grade moron for whom the schools were originally intended. A question arises as to whether custodial cases are to remain as such, or whether, by a broadening of the boarding-out program, they can be moved into the community, where, we believe, they will be as happy as they now are in the schools.

By building up the schools to the 2,000-bed limit, and moving custodial cases into the community when feasible, additional accommodations will be provided for high-grade morons. We wish to emphasize the importance of training this type of the mentally deficient.

High-grade morons have been successfully trained in the schools to assume a very definite place in society and become, as a result of this training, an asset rather than a liability. The plight of the untrained high-grade

moron is a tragic one — he considers himself misunderstood because he, himself, cannot understand. The possibility of his becoming a defective delinquent increases with time. If, however, he can be admitted to a state school, trained in the aptitude for which he seems best developed, and then returned to the community, he soon finds his niche in society and lives a satisfactory existence. Thus, early training equips these young people to resist the pressure of modern existence under which, without that training, they are more likely to break down completely later in life.

Community care of the mentally deficient means to keep them in the community. By doing so the State is saved the capital investment for buildings to house them, the maintenance of those buildings, and the salaries of additional personnel. In addition to the purely financial side of the matter it is a good thing for the mental defective and for the community that he remain out of the hospital as long as it is consistent with his welfare and the public at large. It is essential, therefore, that an extensive program of community care for the mentally deficient be carried on, and this matter is discussed in detail in Section 2 of Appendix 6.

A committee of superintendents, recently created by the Department, will study this problem in the future. It has many angles which merit long and serious consideration, and all factors involved should be thoroughly studied to determine who should be accommodated in the proposed new facilities.

PSYCHOTIC CHILDREN.

The problem of psychotic children has long interested those engaged in the study of psychiatry. Unfortunately there is no special institution for these children in Massachusetts. We have recommended the construction of a 100-bed building on the grounds of the Metropolitan State Hospital in Waltham.

If such a building is constructed it will be possible to segregate children so that contact with adult psychotics

will be impossible; also it will make it possible to remove psychotic children from the state schools where they now mingle with the mentally deficient children.

Experience has shown that by segregating psychotic children the probability of curing them is greatly enhanced. In addition, congregating the children will permit concentration on effort designed to cure them. (See Appendix 14.)

DEFECTIVE DELINQUENTS.

We believe the problem of the defective delinquent is primarily a correctional one, although complicated by a mental condition. In our opinion they can be better accommodated at Bridgewater State Farm, particularly when overcrowding is relieved by the release of quarters now assigned to the criminally insane. We recommend that the Department of Mental Health lay out a program of treatment to be applied by properly qualified personnel in the Department of Correction.

Increased facilities in the defective delinquent section of Bridgewater will be of considerable assistance to the Massachusetts Training Schools in solving a vexing administrative problem. Occasionally there are sentenced to the schools boys and girls who, it is believed, should properly be at Bridgewater.

We have recommended a law which will permit the trustees of the training schools to transfer an inmate to the defective delinquent section at Bridgewater for examination. If found not to be a defective delinquent the inmate will be returned to the training school. If found to be a defective delinquent, however, he could be kept at Bridgewater away from harmful contact with the inmate population in the training school until — unless an earlier release seems warranted — he is twenty-one years old. At that time a re-examination shall be made, and if his condition warrants he shall be brought before a court for recommitment. (See Appendices 4, 6 and 10.)

HOUSING OF EMPLOYEES.

We recommend that as many hospital employees be allowed to live off the institution grounds as may seem reasonable and proper to the superintendents, among whom there is a considerable difference of opinion on this policy. We have done so in the belief that as many employees as possible should enjoy a normal home life with all the advantages that go with living in a community rather than in a hospital. This might prove a desirable inducement to many who dislike living in an institution.

At first glance this policy may appear to be a costly one because of the salary increases granted in lieu of maintenance, but it will pay dividends in the savings in capital investments for employee's homes. In addition, various problems of supervision that go along with living in the hospital will disappear with advantage to all concerned. (See Section F, Appendix 2.)

Food.

This subject has been thoroughly studied for many years. A new system of estimating budgetary needs has been put into effect, and, by and large, has worked well and receives the co-operation of the superintendents. The Department is engaged in the study of purchasing, cooking and serving foods with a view to serving well-cooked food with the greatest efficiency. A committee of superintendents has been appointed to study the ramifications of this important subject, and will recommend changes in policy to the Department periodically as the need is indicated. It does not seem advisable for the Commission to make a recommendation of policy on a subject which changes from time to time. (See Subsection II, Section B, Appendix 9.)

Clothing. — This is another important item of cost. We recommend that the Department of Correction, which provides the clothing for patients in the mental hospitals, confer with the Department of Mental Health

to perfect means of installing a system of annual production. The savings, we have been told, will be enormous. The Department of Mental Health has a certain minimum number of patients in its hospitals at all times, and it seems that the needs of these patients could be accurately gauged well in advance of actual needs. With the hospital clothing orders grouped together, the Department of Correction could buy materials in larger quantities at a lower cost. This would result in substantial savings to the State and to the taxpayers. (See Subsection IX, Section B, Appendix 9.)

Furniture. — What is true of the interdepartmental procedure in regard to the purchase of clothing also applies to furniture. (See Subsection X, Section B, Appendix 9.)

EDUCATION, RESEARCH AND PREVENTION.

We thoroughly believe that a policy of educating the public in matters relating to mental diseases will be most effective in removing the stigma unfortunately still fixed in the public mind in regard to a patient in a mental hospital. Furthermore, the medical profession as a body should receive the benefit of this educational process so that the knowledge of the advances in psychiatry will be available to its members. As a result, earlier diagnosis will be made in many cases, and this is likely to shorten the period of treatment and hasten the discharge of the patient.

In co-ordinated research lies the hope for the prevention and cure of mental diseases. Over a period of years the Rockefeller Foundation and similar agencies, as well as private individuals, have encouraged research by contributing sums to those States and institutions which have shown they merit such consideration. This contribution to pure science is worthy of the highest praise.

In this respect Massachusetts has been treated generously by the Rockefeller Foundation, the Memorial Foundation for Neuro-Endocrine Research, the Armour

Foundation, the Worcester and Springfield Community Chests, and other philanthropic organizations, as well as private individuals. In itself this is an indication that Massachusetts has not lagged behind in research, but that it is consistently forging ahead. We wish to thank these contributors for their assistance and co-operation in the past, and express the hope that in the future Massachusetts will warrant further generous consideration. (See Appendix 8.)

In past years the Department issued a quarterly Bulletin containing articles of value to those in the field of psychiatry. In the opinion of those who read it while it was being published regularly, the Bulletin had fallen low because the format and printing were poor. There is a small sum available for the printing of the Bulletin quarterly, but it would be exhausted in one issue. We have recommended legislation in Appendix 10 which would permit the Department to accept advertising for the Bulletin.

This advertising revenue, in addition to money received from an expanded circulation, would permit the modernizing of the format and a material improvement in the quality of the printing. If the money received through the Bulletin exceeds actual needs the excess money could be used to support a publication intended for the hospital personnel and the general public. This, we believe, would aid the Department in its program of educating the public as to its work. (See Section A, Appendix 8, and Appendix 11.)

LAWS.

We have studied the laws relating to the Department and the hospitals and make our recommendations for changes in Appendix 10. Preceding each recommendation for a change is a summary of the reasons for the recommendation.

THOROUGH INVESTIGATION OF EACH HOSPITAL.

A complete investigation of the medical administration of the hospitals and schools under the Department has

been made by Dr. Hamilton, referred to above. His survey, hospital by hospital, is given in Appendix 11.

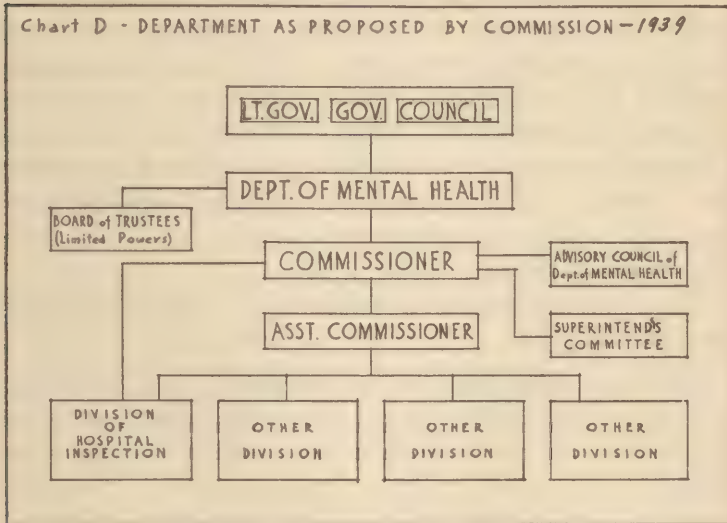
A study of the "whole matter of the mentally diseased in their relation to the Commonwealth" takes in many phases of the work which require a large knowledge of the subject and intense study of its many phases. During its investigation the Commission studied many branches of this subject to which it could not, because its time was limited, make extensive surveys. We have included in our Appendices full discussions of these important phases of psychiatry, but have not made specific recommendations. These Appendices are included because of their informative value.

In our opinion the Department of Mental Health should be a living organization constantly studying every possible means to reach higher standards. It should not be concerned primarily with the actual administration of the hospitals, but should exercise constant vigilance to insure that these standards are maintained.

The problem is one of persistently endeavoring to improve standards which change from year to year as knowledge increases and new methods are devised. These changes come more quickly than the layman realizes, and the Commission felt it was inadvisable to enter into the purely administrative activities of the Department. But it did concentrate on policies intended to include the administration of the Department and hospitals, for we believe the solution lies in an alert organization which is continuously checking its methods and techniques.

The Department has such an organization, but we believe this would be strengthened by an advisory body which we refer to later (Chart D). Standing committees have been appointed to study subjects of vital concern to the hospitals, and others will be appointed as the need develops. These committees are composed of superintendents and representatives of the Department.

By changing the personnel of these committees periodically the superintendents and Department representatives will become familiar with the major problems confronting the Department. The knowledge thus gained should accrue to the benefit of the patient in better treatment, and to the taxpayer in checking the mounting cost of caring for the mentally ill.



Thus far committees have been named, as follows: Legislation and Regulations, Finance, Publicity and Scientific Publications, Food, Construction and Maintenance, Personnel and Labor Relations, Nursing, Mental Hygiene, Statistics and Forms and Care of Institution Patients.

However, it is equally important, in the opinion of the Commission, that when these committees make recommendations to the Commissioner he have a group with whom he can consult before reaching a decision on major policies. One of the reasons for establishing the former unpaid associate commissioners was to give the Commissioner an opportunity to discuss his problems with men from outside the State service who could look at his problems from a different point of view.

We believe the principle should be retained, and have recommended the establishment of a Board to be known as the Advisory Council of the Department of Mental Health, to be composed of men of substance and standing in various lines of endeavor, who would give the Commissioner the benefit of their experience to help him cope with the problems of the Department.

By concentrating the power of appointing these men in the Commissioner, he is assured of a group which will work in sympathy with him. We have deliberately omitted any reference in our proposed legislation to the number of councillors, the term of office, or nature of their duties, so as not to handicap the Commissioner or the Council. Later, perhaps, the Council may be more formally organized, but we would rather wait until time has shown the need.

The Commission wishes publicly to express its appreciation to —

The superintendents of the hospitals, and especially Dr. Morgan B. Hodskins, superintendent of the Monson State Hospital, who assisted in the survey of the hospitals;

The officials of the Department, and particularly the Commissioner, Dr. Clifton T. Perkins;

The Mental Hospital Survey Committee, and particularly Dr. Samuel W. Hamilton and Dr. Grover A. Kempf;

The Rev. Otis F. Kelly, who assisted in the survey of the hospitals;

Dr. L. Vernon Briggs, who assisted in formulating the building program;

— for the splendid co-operation given the Commission in carrying out its duties.

The body of the report represents the conclusions of the Commission, but we have not hesitated to include in the Appendices full discussions on various subjects prepared for our use by the superintendents and the Department officials, but these do not necessarily represent the formed opinion of the Commission on these subjects.

APPENDIX 1.

REPORT OF SPECIAL COMMISSION, 1937.

A Special Commission was created for an investigation and study of the whole matter of the mentally diseased in their relation to the Commonwealth, including all phases of the work of the Department of Mental Diseases, under chapter 7 of the Resolves of 1937, which follows:

Resolved, That an unpaid special commission, consisting of seven persons to be appointed by the governor, is hereby established for the purpose of making an investigation and study of the whole matter of the mentally diseased in their relation to the commonwealth, including all phases of the work of the department of mental diseases, particularly as set forth in so much of the address of His Excellency, the Governor, printed as current senate document number one as relates to mental diseases. Said commission shall hold hearings, may require of the department of mental diseases, and such other department, commission or officer of the commonwealth, as has or can obtain information in relation to the subject matter of this resolve such assistance as may be helpful in the course of its investigation and study, may require by summons the attendance and testimony of witnesses and the production of books and papers as relate to the matter under investigation. Said commission shall be provided with quarters in the state house or elsewhere and may expend after an appropriation has been made for legal, clerical, and other services and expenses, such sums, not exceeding, in the aggregate, seven thousand dollars, as may hereafter be appropriated. Said commission shall report to the general court, the results of its investigations and study and its recommendations, if any, together with drafts of legislation necessary to carry its recommendations into effect, by filing the same with the clerk of the house of representatives not later than the first Wednesday of December in the current year.

To understand the work of the Commission it is necessary to realize that in the period preceding the inaugural message, and the recommendation of the Governor for the establishment of the Commission, certain occurrences in the Depart-

ment of Mental Diseases and the Boston State Hospital attracted a great deal of attention and were given considerable publicity in the newspapers. Subsequently, the Department submitted its annual budgetary request, asking for an appropriation of approximately \$12,000,000 for ordinary current expenses of the Department and the hospitals under its jurisdiction, and the staggering sum of approximately \$17,000,000 more for new construction of buildings and radical alterations in existing buildings.

These circumstances convinced the Governor that the matter was urgent, and led him to request the establishment of a Special Commission in his inaugural message. That portion of the Governor's message follows:

There is an important phase of administration which has seriously disturbed the Governors of Massachusetts for many years. I refer to the problem of the mentally diseased. I would, first of all, call to your attention that the care of those unfortunately thus afflicted has normally absorbed about one quarter of the active income of the state.

I think it is only fair to say that none of my predecessors has ever begrudged the spending of this large proportion of our revenue. Certainly, I am, and shall continue to be, in entire sympathy with every reasonable request for appropriations toward this eminently worthy cause.

However, there has been, for some years, a definite sentiment in administrative circles that there should be instituted some form of legalized review and analysis of the affairs and of the plans of the Department of Mental Diseases. Let me say at once, for the benefit of those who may have relatives or friends in our state hospitals, that the sentiment has not been engendered by reports of any physical abuse of the inmates of these institutions. On the contrary, our traditions in this regard are very high and very sound.

Specifically, there is reason to believe that the proper care of the mentally sick, for which the Commonwealth holds itself duly responsible, is gradually being extended into fields where we cannot sensibly assume responsibility. There is in the public mind an ever-growing tendency, which has been deliberately fostered and directed, to throw upon the care of the Commonwealth many who should and could be cared for at home. The practical distinctions between the insane, the neurotic, the moronic, and the retarded are being obscured, to all intents and purposes, so as to favor the shifting of humane responsibility for the care and the upbringing of all these types from the home to state institutions. Theory and practice are being most plausibly confused in the elusive name of science.

These constantly expanding operations of the Department of Mental Diseases are supported by what are practically the police powers of

the State. As you can all see, we must be correspondingly on our guard against the possibility of officious error and injustice. Already this Department has tremendous authority over the lives of 25,000 of our people. Without a scientifically limited and publicly approved program, it is quite possible that, at some future day, the Department may come under the control of a politically powerful group who may love theory because it is novel, and who may define efficiency in terms of number of inmates and of unlimited extension of building operations and of personnel.

This brings me at once to the matter of finance. Our former Commissioner of Mental Diseases, on November 30, 1936, filed a series of requisitions which would have entailed the expenditure of \$28,000,000, — over two and one half times as much as was spent by the Department last year. On submitting the details of these requisitions to a group of men trained by education and experience in the practical and scientific aspects of the problem, I was informed that the program outlined was unsatisfactory in several important details, — details involving the expenditure of millions of dollars of state funds.

In the light of these facts I suggest that the Legislature empower me to appoint a commission to consider the whole matter of the mentally diseased in their relation to the Commonwealth. I would have the members of this commission submit a complete program which would envisage our needs for the next decade, at least. I would have them include in this program a correct outline of the obligations and of the rights of the Commonwealth in the light of modern, scientific knowledge and practice, and I would have them draw up a complete scheme of building operations sufficient to meet our requirements for years to come, eliminating all unbusinesslike or overlapping details caused by haphazard planning. Fragmentary handling of this problem is no longer excusable.

Therefore, I respectfully request from your honorable bodies the power to appoint a commission of five members, composed of a competent specialist in mental diseases, a tried and skilled hospital administrator, a builder or an architect who understands well the material aspects of hospital construction, an outstanding medical man in general practice, and a jurist thoroughly acquainted with the problems of juvenile delinquency. I ask that this commission be empowered to investigate all phases of the work of the Department of Mental Diseases, and that it be authorized and directed to engage in such study as will enable it to bring in for our consideration a complete, practical and scientific plan for the wise handling of this problem in a systematic and truly state-wide fashion during the next ten years.

It is our hope that such a plan, wisely conceived and clearly developed, will serve as a directive norm for those who may be responsible for the work of this important Department. It is my further

hope that this plan may be a model for all those, whether at home or abroad, who are sincerely interested in the public care of the mentally defective.

Under authority of the resolve the Governor appointed the following persons to the Commission:

Judge John F. Perkins, Milton.
Maj.-Gen. Erland F. Fish, Brookline.
The Rev. Otis F. Kelly, Brighton.
Judge Joseph W. Monahan, Belmont.
Dr. L. Vernon Briggs, Boston.
Representative Thomas P. Dillon, Cambridge.
Mr. John M. Gray, Salem.

Members of the Commission were sworn into office by the Governor on April 26, 1937. At the first meeting of the Commission, held that day, Judge Perkins was elected chairman, Major-General Fish was chosen as vice-chairman, William J. Griffin was named secretary, and Margaret R. Cotter was appointed stenographer.

The Governor spoke briefly to the Commission. He referred to his inaugural message and said he felt that there was a real need for a thorough and impartial investigation of the whole matter of the mentally afflicted, and their relationship to the State. He related that he is intensely interested in the welfare of the mentally ill, but is also cognizant of the fact that the Department of Mental Diseases now absorbs about one quarter of the active income of the State. He told the Commission that he hoped that upon the completion of their investigation the members would be able to present a report that would be helpful to those in charge of the Department, and also be of benefit to the taxpayers.

ACTIVITIES OF THE COMMISSION.

The magnitude of the task confronting the Commission was fully realized from the start. In its endeavors to obtain information that might be helpful in formulating a program — a program which would better the welfare of the 28,000 patients and the 7,000 employees of the Department, and still be of benefit to the taxpayers — the Commission has sought information from every source available. It visited the Department of Mental Diseases and various hospitals under its

jurisdiction; attended meetings of the Department and the superintendents of the state hospitals; staff meetings at various hospitals; trustees' meetings at various hospitals; meetings of the Department and the trustees of all hospitals; and meetings of the Commissioner of Mental Diseases and the Associate Commissioners.

In addition, it held hearings which were attended by the superintendents, individually and as a group; by the Commissioner of Mental Diseases and his chief executive aides; the Commissioner and the Associate Commissioners; representatives of the Auditor's Department, the Department of Correction, and the Commission on Administration and Finance. Assistance was also received from the Boston School Committee, the Rockefeller Foundation, the New York State Department of Mental Hygiene, and the National Committee for Mental Hygiene.

IMPORTANCE AND NEED OF INVESTIGATION.

The importance and need of the investigation of the care of the mentally ill in Massachusetts was amply indicated in the Governor's message to the Legislature.

Because of the peculiar treatment required — often prolonged — the majority of the mentally ill must be cared for at public expense, — a duty which the State recognized and assumed many years ago. The financial burden to the State, therefore, for buildings, equipment, maintenance and salaries of officials and employees, constitutes one of the largest items in the annual budget.

The constant increase in this tax burden has, as the Governor pointed out in his message, "seriously disturbed the Governors of Massachusetts for many years." At no time since its creation has the Commission forgotten that, among other duties, it represented the inarticulate taxpayer who supplies the money to run this huge Department.

For many years Massachusetts has had the reputation throughout the country of being a leader in the care of the mentally ill. The methods of providing for hospitals and administering hospitals in this State have been imitated by many of our sister States. Many States have found it wise to engage permanently the services of physicians who received their training in the Massachusetts state hospitals. Many States, too, have temporarily borrowed the services of superintendents of our state hospitals to organize their own departments for the

care of the mentally ill. Only recently the Governor of Kentucky requested Governor Hurley to permit a superintendent of a state hospital to go there to assist and direct them in the organization of a new and modern state hospital modeled on the Massachusetts system.

The Commission has been strongly impressed by the very evident fact that in many and probably most instances the mentally ill in the state hospitals of Massachusetts are provided with far better surroundings and better medical and surgical care than are available to the average citizen in comfortable circumstances when he becomes sick.

We have dwelt on the excellence of the care provided by the State for the mentally ill because recently, in newspapers, popular literature and even in medical psychiatric literature articles have been published which give the idea that the Massachusetts care of the mentally ill has broken down, and the whole Department of Mental Diseases has become honey-combed with politics.

The citizens of this State may be reassured on this point. It is true that the Department organization at the State House broke down this year, and that for several years it has not given the hospitals the assistance and co-operation they have a right to expect; and in some cases laxity has crept into the hospitals.

On the whole, however, the hospitals have maintained their standards, and the work of caring for the mentally ill, of encouraging preventive measures in their communities, and of conducting research projects has been carried on with high fidelity to the best traditions. For this the superintendents deserve high praise. We wish also to express our thanks to the superintendents, and to the Acting Commissioner, Dr. Clifton T. Perkins, and his associates in the Department, for their help and admirable spirit of co-operation.

THE DEPARTMENT OF MENTAL DISEASES.

History and Present Condition.

The Commonwealth of Massachusetts began to care for the mentally ill as early as 1832, when a mental hospital was established in Worcester. Previously, insane persons were incarcerated in jails, hidden in almshouses and frequently brutally treated.

In 1854 a Special Commission on Lunacy was appointed to ascertain the number and condition of the insane, and this

commission made definite recommendations. Later, in 1863, a committee was appointed to make further investigations and this committee recommended that a permanent Commission on Lunacy be appointed.

The State Board of Charity was established in 1863, and, for the first time, the insane of Massachusetts came under central supervision. This Board was later superseded by the State Board of Health, Lunacy and Charity. A State Board of Insanity was formed in 1898, was reorganized in 1912 and again in 1914. The Massachusetts Commission on Mental Diseases, now the Department of Mental Diseases, succeeded this Board in 1916.

Wise legislation for the insane began in earnest in 1881. Voluntary admission, which was used in the early days, was re-established that year. Provisions were also made for emergency admission. With the inauguration of state care, a separate division was established by the Department in 1904 to study the question of support of patients. State care of the feeble-minded and epileptic became effective in 1908. When the Department was established as such in 1916, Dr. George M. Kline was chosen Commissioner, and remained Commissioner until his death in January, 1933. Dr. James V. May was Commissioner from January, 1933, to June, 1934, when he was succeeded by Dr. Winfred Overholser, who in turn was succeeded by Dr. David L. Williams, the present Commissioner.

The Department of Mental Diseases, already well organized by the previous Boards of Insanity, was managed most efficiently during the long service of Dr. Kline, from 1916 to 1933. Dr. Kline devoted all of his time to the work of the Department, and exercised a degree of control not attained by any other Commissioner. He constantly visited the hospitals, kept himself familiar with the problems and needs of the hospitals, and took a deep personal interest in the officers of the hospitals, particularly the medical officers. He studied their abilities, to know better how to encourage them and to help them to cultivate their talents. For that purpose he instituted the custom of bringing to the Department, as assistants to the Commissioner, physicians who had the grade of assistant superintendent of a hospital. His plan was to train these young men for superintendents when vacancies occurred. Working in the Department under Dr. Kline these men were expected to become familiar with administrative methods and to get the so-called "Department view-point." By conducting hospital in-

spections, they were expected to become familiar with all the details of hospital administration. This system worked reasonably well under Dr. Kline because of his personal talent and enthusiasm. But even under Dr. Kline the method was more effective for training prospective hospital superintendents than for promoting the welfare of the hospitals, because the inspectors were not the equals of the superintendents in training and experience, and their inspections were not so valuable or effective as inspections should be.

Under Dr. Kline the Department had become a one-man affair. Subsequent commissioners were not men of such outstanding executive ability as Dr. Kline, and the Department, under their régime, began to lose its vigor.

The appointment of Dr. Williams, who was confirmed December 9, 1936, was severely criticised as a purely political appointment, and it was alleged that he did not have the necessary qualifications to perform the duties of his office. He carried on as Commissioner until May 20, 1937, when he was taken sick, and has not reported for duty at the State House since that time. However, he still remains Commissioner. Shortly afterward, Dr. Joseph E. Barrett, the assistant commissioner, who was Acting Commissioner in the absence of Dr. Williams, resigned under charges preferred by the State Auditor.

This left the Department without an active legal head, and conditions in the Department soon became nothing less than chaotic. The Governor could not appoint a new Commissioner as the office was not vacant; and there was no assistant commissioner. Under the law a new assistant commissioner must be appointed by the Commissioner, who could not be reached. This condition lasted until June 23, 1937, when Dr. Williams recovered sufficiently to appoint Dr. Clifton T. Perkins as assistant commissioner. In the meantime, a large volume of matters, which legally required the action of the Commissioner or Acting Commissioner, had accumulated, and the personnel of the Department was for a long time busily engaged in disposing of this accumulated business.

Reorganization of Department.

In consequence of these conditions the work of the Department has become ineffective, both in its internal administration and in its supervision of the various hospitals under its

jurisdiction. We believe a complete reorganization of the Department is called for. The Commission therefore recommends —

A. *The abolition of the Department of Mental Diseases.*

B. *The creation of a new department to be known as the Department of Mental Health.*

Care of the mentally ill is a medical problem, but recognition of this has been extremely slow. However, the stigma and public disgrace formerly attached to the mentally ill and their families have gradually diminished, so that people have become more and more willing to admit the existence of mental disease and to seek medical care. The growing need for additional hospitals is largely due to this changed attitude.

In recent years the work of the Department of Mental Diseases and the hospitals under its control has expanded to include not only the care and treatment of those already mentally ill, but also measures for the prevention of mental diseases, for the education of the public, and for research to determine the causes of mental diseases. In addition, the Department has furnished assistance to the schools of cities and towns by examining retarded children and establishing special classes for the education of mentally deficient children for whom hospitalization is not necessary.

The term "mental health" more nearly describes the present work of the Department.

C. *The executive control of the Department of Mental Health to be in the hands of one Commissioner, with two Associate Commissioners to assist him.*

The Department is now composed of one full-time Commissioner and four unpaid Associate Commissioners, whose work is largely advisory. When interviewed by the Commission, the Associate Commissioners readily admitted that with the extensive outside activities which they all have, it is impossible for them adequately to perform the duties the law requires; that for many years the Commissioner has dominated the Department; and that their work has been little more than a formality. They have been generous with their time and efforts, but their duties have become too burdensome to be handled effectively by them.

The Commission considered three possible plans of departmental administrative control:

First. — A full-time Commissioner, who would be the executive head of the Department, and a board of advisers, who would, on occasion, give him their views on the pressing problems of the Department.

Second. — A three-man Commission, each Commissioner having equal powers, who would divide the work of the Department.

Third. — A Commissioner who would be the executive head of the Department, but who would have two well-qualified and able associates to whom he could turn over a great part of his work.

After lengthy discussions the Commission came to the conclusion that the third plan gave greater promise than the others. It combines the advantages of a single Commissioner, and the three-man Commission. The Department, according to the best estimates, will continue to expand; and to increase the load on a single Commissioner would be unwise. On the other hand, to divide the responsibility for administering the affairs of the Department would be equally inadvisable.

To carry out this plan there should be a full-time Commissioner, whose duty it would be to see that the work of the Department is properly and efficiently carried on.

There should also be a first Associate Commissioner, with professional qualifications equal to those of the Commissioner. As his chief duty he should maintain active and intelligent contact with the hospitals for the mentally ill. The first Associate Commissioner, therefore, should be in charge of the hospital inspection service, to which we refer later. It would be his duty to make certain that the hospitals receive the assistance and co-operation they have a right to expect from the Department, and have not received in the past few years; that the hospitals are maintained according to the best standards of medical practice; that public moneys expended in hospitals are expended for useful purposes, and not wasted on things that are more decorative than helpful to the patients.

There should also be a second Associate Commissioner, who should be a physician, familiar with hospital administration for the care of people who suffer from diseases common to both sane and insane. He should be a man whose standing and authority would command the respect of hospital superintendents and officials, and it should be part of his duties to see that the standards of general medical care are maintained without extravagant expenditure of state money.

To obtain continuity in the Department, it is recommended that the terms of the Commissioners be six years, and that their appointments be staggered at the start so that there will be an appointment every two years, thus leaving at all times two men thoroughly familiar with the policies and aims of the Department.

To command the respect of the many highly trained men in the various hospitals, those in charge of the Department should be highly trained themselves, and by their achievements should have reached a position of eminence in their profession. To obtain such men, adequate salaries must be paid. It is therefore recommended that the Commissioner be paid not less than the sum of \$10,000 per year, and the Associate Commissioners not less than the sum of \$9,500 per year.

This plan leaves administrative authority in the hands of one man, but associates with him two other men who also have the title of Commissioner and who are qualified professionally. They will share the work and, although subordinate to him, will be qualified to perform his duties in the event of his sickness or absence. By this arrangement the Department at all times will be in charge of a competent head, familiar with its work and its problems, and able to command the respect of the hospital superintendents and other subordinates.

D. The Commissioner and first Associate Commissioners to be diplomates of the American Board of Psychiatry and Neurology, and to have had at least seven years' experience on the staff of a State or Federal hospital for mental diseases, or in any equivalent psychiatric organization. The second Associate Commissioner to be a physician with at least seven years' experience on the staff of a general hospital.

It is impossible to define by law all the qualifications that men should have to hold executive positions in the Department and in the hospitals. It is, however, of the highest importance that minimum qualifications be required so that the many thousand patients in the State's care shall not suffer through the incompetence of executives, and the taxpayers shall be protected from expensive, inefficient and unwise administration. Proved ability and experience are the qualities desired, and although there can be no certainty in advance that a man will perform new duties effectively, the requirements we recommend go a long way toward assuring this result.

A diploma from the American Board of Psychiatry and Neurology is the recognized indication of competency in the practice of either psychiatry or neurology. Any physician is eligible for examination and certification by this Board if he meets the professional requirements demanded by it before the issuance of a diploma.

For further details regarding the American Board of Psychiatry and Neurology, see Appendix A.

E. *The work of the Department of Mental Health to be administered through various divisions.*

1. *The Division of Hospital Standards and Inspection.* — Under the present law (section 24, chapter 123, General Laws) one of the most important duties of the Department is the inspection of hospitals. To inspect a large hospital adequately the inspector should spend at least a week in the hospital. (For inspections made in recent years see Appendix B.)

It will be seen from the list of inspections that since 1933 only three hospitals have been inspected by the Department of Mental Diseases in the manner prescribed by law; namely, the Westborough State Hospital in 1934, the Boston State Hospital in 1935, and the Northampton State Hospital in 1936, with a supplementary report in 1937. In addition to this there was one inspection of the Hospital Cottages for Children in 1936.

Examination of inspections of private hospitals shows a comparable situation. The two Veterans Administration Hospitals for Mental Diseases in Northampton and Bedford have not been inspected by the Department since 1933. These records are taken from the Department of Mental Diseases.

Not only did the Department fail in the number of inspections which good administration and the law require, but also in their quality. Enough time was not given, and of the time given much was wasted in trivial and unimportant details. Until recently, whole days were spent in checking commitment papers which had been previously checked by hospital employees; and the time remaining was devoted mainly to an examination of the physical properties. Little of medical value appears in the reports. They were filed under the name of the inspecting doctor, not under the name of the hospital, and very little, if anything, was done about them.

The Commission wishes to emphasize, as forcibly as possible, its belief that the true function of inspections is something

quite different from the trivial checking of details which has prevailed in the past. Their purpose should be to help, and to stimulate improvement, not merely to find fault. They should be used to keep all hospitals in a state of friendly rivalry for leadership in better methods and higher standards; and under skillful direction, they should become a most valuable and effective tool in producing good management.

Owing to the importance of this division it is suggested that it be headed by the first Associate Commissioner. But the director of this division, whether first Associate Commissioner or not, should be thoroughly familiar with hospital practice. If not first Associate Commissioner, he should be a diplomate of the American Board of Psychiatry and Neurology, and should have had at least five years' experience on the staff of a State or Federal hospital for mental diseases, or in any equivalent psychiatric organization. He should have a competent staff to make the investigations, including experts in the psychiatric and medical care of patients, food experts, and such other experts as he may need to perform properly the duties assigned to this division.

2. *The Division of Mental Hygiene, Statistics and Research.* — The number of patients in the hospitals of the Department has been constantly increasing and promises to continue to do so.

Obviously the way to attack the problem is to treat cases in their first stages, and also to encourage preventive measures and research. For that reason the Commission recommends a Division of Mental Hygiene, Statistics and Research, to co-ordinate research work and the preventive measures of the Department.

The director of this division should have the same qualifications as the director of the Division of Hospital Standards and Inspection.

3. *Division on Construction, Maintenance and Equipment.* — The work of this division is non-medical, and should be headed by a professionally competent construction engineer or other person of similar capacity. Its duties are twofold: first, to see that adequate physical facilities are provided for the proper care of the mentally ill; and second, to see that in so doing no money is wasted.

A building program should be worked out. All types of buildings should be standardized. All specifications and contracts should be studied and approved by the division. Under

present conditions, private architects and engineers who are employed to prepare plans and specifications vary widely in their ability to produce economical projects. Sometimes hospital authorities, in their endeavor to surpass other state institutions, forget the importance of economy, and the present Department authorities, owing to their lack of technical knowledge, fail to detect and veto the unnecessary expense.

The same thing is true in regard to the purchase of equipment. The process of standardization which the Commission on Administration and Finance has been working toward for years should be developed much more intensively. All requisitions should be studied, and only approved when they conform to the standards prescribed by the division.

This whole question of construction, maintenance and equipment is more fully discussed in Appendix C.

4. *Other Divisions.* — The Commission felt at one time that all the business activities of the Department should be handled by a Division on Finance, Settlement and Support. To do so might hamper the Commissioner in setting up his Department. So such a division is not recommended. But the Commissioner is empowered, as he is under the present laws, to establish such other divisions as he may from time to time determine, and assign to those divisions their functions.

Relation between the Department and Hospitals.

1. *Superintendents.* — Under the present law the power to appoint and remove superintendents is vested in the Boards of Trustees of the various hospitals. These Boards, composed as they are of high-minded citizens willing to give their services generously to the Commonwealth, are of the greatest value as a link between a hospital and the community which it serves, and are universally looked upon by the superintendents of the hospitals as their most valuable allies in maintaining intelligent and friendly relations with the people of the community. But that such Boards should be able to judge the qualifications and competency of physicians in medical matters is not to be expected, and, with few exceptions, they have appointed as superintendents men recommended to them by the Department of Mental Diseases. It seems obvious that as the superintendents are the responsible heads of the medical and business administration of their hospitals, they should be directly accountable to the Department which is primarily responsible for the care of the mentally ill.

The Commission therefore recommends that the power to appoint and remove superintendents be vested in the Commissioner of Mental Health, with the approval of at least one Associate Commissioner. Machinery to safeguard the rights of a superintendent in case his removal is sought is provided for in the proposed law.

2. *Qualifications of Superintendents.* — It is vitally necessary to have men of the highest caliber as superintendents of the various institutions for the mentally ill. To insure the appointment of such men, and to prevent the appointment of unfit men through favoritism or politics, the Commission recommends that the qualifications of superintendents be the same as those for the directors of the Division of Hospital Standards and Inspection, and the Division of Mental Hygiene, Statistics and Research.

It would be manifestly unfair to demand that the present hospital superintendents be suddenly ousted from their positions because they are not diplomates of the American Board of Psychiatry and Neurology. In our proposed reorganization we have inserted a provision that such requirement shall apply only to superintendents hereafter appointed.

3. *Trustees.* — Under the present law the Boards of Trustees are appointed by the Governor and Council. They are unpaid, and have many onerous duties in connection with the administration of their hospitals. It is obvious that no Board of unpaid citizens, for the most part not physicians, and not familiar with problems of medical administration, can properly and satisfactorily perform all the duties imposed upon them. Usually the Trustees consider themselves merely as approvers of the actions of the superintendent, except in cases of flagrant incompetency or misconduct, and act largely in an advisory capacity in business matters, leaving the details to the superintendent and the Department of Mental Diseases. The Department has, in fact, performed most of the work assigned by law to the Trustees.

The Commission therefore recommends that the Boards of Trustees be retained as at present constituted; that they act as Trustees for certain property, both real and personal, as at present provided by law; that they be required to maintain familiarity with their respective hospitals and hospital matters; that they make special investigations in their respective hospitals when such are needed; and that they be authorized to make recommendations to the Department when they find

conditions existing which they think should be remedied by the Department; but that full control of the hospitals be vested in the Department of Mental Health, and all powers and duties now in the Trustees, except as enumerated above, be transferred to the Department.

Under this arrangement the Trustees would continue to exercise their most valuable function as a bond and as a means of communication between the hospital and the community it serves. They would serve as a check on both the hospital superintendents and the Department as representatives of the citizens.

CONTINUATION OF THE INVESTIGATION.

A. *Building Program.*

One of the principal purposes for which the Commission was appointed, as indicated in the Governor's inaugural message, was to formulate a ten-year building program. Because of the conditions already described, it has been impossible to prepare such a program in the time available. The following factors will indicate, to some extent, the necessity for thorough consideration of this subject:

1. *Size of Hospitals.* — In this State the traditional maximum size of a state hospital has been 2,000 beds. Experience has apparently demonstrated that when this limit is passed care for the patients with reasonable economy is not feasible. In certain other countries the maximum size of the institutions for the insane is placed at 1,100 beds. Nearly all of the state hospitals under the Department of Mental Diseases are at present overcrowded. Several of them have not yet been completed to provide 2,000 beds.

What constitutes the proper size for a state hospital raises many questions requiring further study.

2. *The Care of the So-called Criminal Insane.* — The Legislature has already enacted enabling legislation for the transfer of the criminal insane at Bridgewater to the care of the Department of Mental Diseases, and the erection of a hospital for their care on land now owned by the Norfolk Prison Colony.

Although this particular plan has been endorsed by those who have given consideration to the question, and although this Commission agrees that the present provisions for this class of patients are not proper, nevertheless we have not been able to study the question sufficiently to approve the location of a hospital of this nature adjacent to the Norfolk Prison Colony.

This question deserves further study in conjunction with a properly functioning Department of Mental Health.

3. *The Care of Mentally Ill Patients at Tewksbury State Infirmary.* — At present there are approximately 500 patients suffering from chronic mental diseases at the Tewksbury State Infirmary. Most of them will have to be taken care of for life in institutions. The Infirmary is no longer permitted to accept new patients from the community. The superintendent of the Tewksbury Infirmary, which is under the jurisdiction of the Department of Public Welfare, has suggested either that these patients be removed from the Infirmary, or that he be given authority to receive new patients from the community and conduct a psychiatric service for them in order to stimulate the practice of psychiatry at the institution. This subject, also, requires further study.

4. *Schools for Feeble-Minded.* — The state schools for the feeble-minded are all over-crowded and have large waiting lists. In 1930 the Legislature authorized an appropriation for the purchase of land for a new school for the feeble-minded. A site was selected at Andover, but owing to the objections of the citizens of Andover, it was not approved by the Governor and Council. The whole problem of the training and education of feeble-minded persons, both in the institutions and in the communities of the State, deserves careful study.

5. *Psychotic Children.* — There is no adequate provision in the state hospital system for the study and care of psychotic children. The few that are at present committed because of the immediate necessity of their receiving scientific care and treatment have to be hospitalized with adult insane because existing accommodations make segregation impossible. This interferes with the proper treatment of psychotic children and prevents the timely care which might save many of them from permanent insanity. The advisability of providing a hospital for such children has been recognized for years, and last year the Federal government allocated \$198,350 for erection of such a hospital. However, it was impossible to secure bids to build the proposed hospital within the sum allocated.

The Department of Mental Diseases recommends a hospital for psychotic children in this year's budget. The Commission has been unable to make a proper study of this subject and therefore makes no recommendation.

6. *Defective Delinquents.* — There are approximately 800 adult defective delinquents cared for at the Bridgewater State

Farm. The proper care and training of these defective delinquents raise a further problem. Here, again, it has not been possible for this Commission adequately to investigate the matter.

7. *Housing of Employees.* — The state hospitals furnish living quarters for the great majority of their employees. The reason for this is clear where a hospital is located at a long distance from a residential district; but is not so obvious when the hospital is in or close to a city or a good-sized town.

During the late depression it was relatively easy to get competent people for attendants and other hospital positions. With the better economic conditions of 1936 and 1937 the state hospitals found it more difficult to get competent help with the living conditions and salaries which the State provides. Without doubt many employees who now live in the hospitals could live more normal lives by having their homes in neighboring communities, without injury to their work, and probably with benefit to it; and this might provide a desirable inducement to many who dislike living in an institution.

Furthermore, to build accommodations for employees is expensive. Recently in one hospital in a large city a very elaborate building was erected for employees at great expense. No adequate study was made to determine how many of these employees could have been housed outside.

The whole question of living accommodations for employees of state hospitals should be carefully considered in connection with the proposed building program.

B. *Food.*

At the time when this investigation was inaugurated, the problem of providing proper and sufficient food for the inmates of state hospitals was receiving considerable publicity. Our investigation has shown us that the patients of the state hospitals have been adequately fed. It revealed, however, that the methods of estimating and determining what appropriations should be made for food are radically wrong. In several cases requests for food appropriations were at least double the amount which the superintendent considered adequate, and were cut in halves with no ill results to the institution. In one instance, where a request for an appropriation was reduced by nearly \$130,000, the superintendent stated that his patients were adequately fed; that if the added \$130,000 had been appropriated he would not have known what to do with it.

We are informed that the Department has already changed its method of estimating the budgetary requirements for food, but there is no doubt that the whole food problem requires further investigation and experimentation in conjunction with a properly functioning Department of Mental Health.

C. Other Conditions and Policies in the Care of the Mentally Ill.

The Commonwealth furnishes care and medical treatment for all patients who come to its hospitals suffering from mental diseases at a maximum charge (except at the Psychopathic Hospital) of \$10 per week. This is collected from an extremely small percentage of the families and friends of patients. The State is also furnishing facilities for the study and care of retarded children, and for the examination of problem children and others at the public expense.

In no other specialty in medicine does the State furnish care for all who apply at a charge which practically prohibits private competition. Private practice in psychiatry is almost entirely restricted to the wealthy. As a result there is little incentive for the best medical students to enter private practice in the care of the mentally ill, and the fact that institutional life is necessary for physicians entering the service of a state hospital acts as an additional deterrent.

This is only a general statement, because in the state service there are many able physicians and psychiatrists with high ideals. Nevertheless, we are convinced that the tendency to place the care of the mentally ill entirely in the hands of the State, and the necessity of institutional life for physicians, have retarded the development of psychiatry as a medical science. This whole question is one of great importance to the taxpayers and to the medical profession, and deserves intensive study.

Incidental to this is the matter of rates charged for patients by the State. It is believed that there are many families who, though unable to afford the expense of private institutions, could well pay more than the State charges. If some practical way of securing additional income from this source can be worked out it should be adopted.

D. Education, Research and Prevention.

The Commission has devoted much thought to the question of research in the Department of Mental Diseases and

its associated hospitals. It is obvious that the care of the mentally ill will continue to be one of the largest burdens on the taxpayers of the Commonwealth unless more successful methods of prevention and cure are discovered. In research lies the only hope of dealing with the problem of mental disease with reasonable success. Unless wisely carried on it is expensive and fruitless. Hitherto the research carried on has been too dependent on the enthusiasm of individuals. It has not had sufficient encouragement and guidance from the Department.

Here, again, is a subject which deserves much careful investigation. Not only should it be studied with a properly functioning Department of Mental Health, but information and advice should also be obtained from private institutions devoted to research.

E. Study of Laws in Relation to Mental Health, particularly regarding Commitments and Discharges.

The laws regarding the different aspects of mental health and disease represent a gradual accumulation of legislation. This should be studied and made systematic and comprehensive, and as simple and clear as such a complex and many-sided problem permits.

F. Thorough Investigation of Each Hospital.

The Commission is convinced that a thorough inspection of each of the state hospitals should be made. Reports on the Boston State Hospital, Westborough State Hospital, Boston Psychopathic Hospital and the Department of Mental Diseases, made by State Auditor Thomas H. Buckley, and submitted to the Governor, have been referred to the Commission, and these reports should be considered when the investigations of various hospitals are made.

The Commission, since its creation in April, 1937, has learned much about the problem which mental disease brings to the Commonwealth, but it has not had time to conduct a complete investigation leading to comprehensive recommendations. With the knowledge already acquired, it should be able to carry on a systematic and thorough investigation if it is re-established by the Legislature, provided it has a properly functioning Department to work with.

We therefore recommend that the investigation already begun be carried to its conclusion, and so that no further time will be lost, we recommend the early passage of the resolve accompanying this report. (For the Resolve see Appendix D.)

For enabling legislation to carry out the recommendations of the Commission see Appendix E.

APPENDIX A.

THE AMERICAN BOARD OF PSYCHIATRY AND NEUROLOGY.

The American Board of Psychiatry and Neurology, Incorporated, with executive offices at 1028 Connecticut Avenue, Northwest, Washington, D. C., is composed of twelve members, four from the American Neurological Association, four from the American Psychiatric Association, and two neurologists and two psychiatrists elected by the section on Nervous and Mental Diseases of the American Medical Association.

The chief functions of this Board are:

- (a) To determine the competence of specialists in psychiatry and neurology.
- (b) To arrange, control and conduct investigations and examinations to test the qualifications of voluntary candidates for certificates issued by the Board.
- (c) To grant and issue certificates or other recognition of special knowledge in the field of psychiatry and neurology to successful voluntary applicants therefor.
- (d) To serve the public, physicians, hospitals and medical schools by preparing lists of practitioners who shall have been certified by the Board.
- (e) To consider and advise as to any course of study and technical training, and to diffuse any information calculated to promote and insure the fitness of persons desirous of qualifying for a certificate of qualification to be issued thereby.

APPENDIX B.

INSPECTIONS MADE IN RECENT YEARS.

State Hospitals.

NAME OF INSTITUTION.	Date.	Time spent (Days).
Boston Psychopathic Hospital	1923	3
	1924	3
	1927	2
	1933	7
Boston State Hospital	1923	16
	1924	2
	1927	8½
	1929	4
	1932	7
	1933	3
Danvers State Hospital	1935	5
	1923	5
	1924	2
	1927	6½
	1932	8
Foxborough State Hospital	1933	4
	1922	4
	1923	4
	1925	2
	1926	3½
	1930	4
Gardner State Hospital	1932	4
	1933	4
	1922	3
	1923	3
	1924	3
Grafton State Hospital	1926	4
	1929	4
	1923	3
	1925	2
	1926	3
Medfield State Hospital	1927	1
	1930	2
	1931	5
	1923	3
	1925	2
Metropolitan State Hospital (opened in 1930)	1927	4
	1930	5
	1932	5
	1933	5
	1932	2
Northampton State Hospital	1933	2
	1923	5
	1924	3
	1926	4
	1929	7
Taunton State Hospital	1932	5
	1936	
	1923	1
	1924	3
	1926	4
	1933	7

INSPECTIONS MADE IN RECENT YEARS — *Continued.**State Hospitals — Concluded.*

NAME OF INSTITUTION.	Date.	Time spent (Days).
Westborough State Hospital	1923	5 ¹
	1923	6 ²
	1924	3
	1927	4
	1930	5
	1932	5
	1933	5
Worcester State Hospital	1934	2
	1923	4
	1924	2
	1925	2
	1926	3½
	1930	4
Monson State Hospital	1932	7
	1923	4
	1925	6
	1926	3
	1929	4
Belchertown State School	1923	3
	1925	2
	1926	2
	1930	2
	1931	5
Walter E. Fernald School	1923	4
	1925	4
	1927	3½
	1929	2
	1931	6
	1933	4
Wrentham State School	1923	4
	1925	3
	1927	3
	1930	5
	1931	4
	1933	4
Mental Wards, State Infirmary at Tewksbury	1922	1
	1923	2
	1925	1
	1927	1
Bridgewater State Hospital	1923	1
	1924	2
	1927	2
	1930	2
Hospital Cottages for Children	1923	3
	1924	1
	1927	1
	1929	1
	1936	1

¹ Full days.² Part-time periods.

INSPECTIONS MADE IN RECENT YEARS — *Continued.**Private Institutions.*

NAME OF INSTITUTION.	Date.
Bournewood Hospital	Oct. 26, 1922 Mar. 9, 1925 Apr. 4, 1927 Oct. 16, 1929 Sept. 20, 1932 May 1, 1933 Jan. 11, 1935 Oct. 25, 1935
Channing Sanitarium	Feb. 16, 1925 Apr. 7, 1927 Sept. 28, 1928 Aug. 22, 1929 Sept. 22, 1932 May 22, 1933 Jan. 8, 1935 Oct. 22, 1935
Dr. Reeves' Sanitarium	Mar. 2, 11, 1925 Mar. 2, 1927 Feb. 17, 1928 Oct. 25, 1929 Sept. 19, 1932 Apr. 26, 1933 July 8, 1935
Glenside	Feb. 11, 1925 Mar. 16, 1927 Jan. 17, 1929 Oct. 21, 22, 1929 Nov. 16, 1932 May 1, 1933 Mar. 30, 1934 June 20, 1935
McLean Hospital	Nov. 6, 1923 Mar. 10, 11, 1925 Mar. 17, 18, 1927 Oct. 23, 24, 1929 June 30, 1932 July 1, 2, 1932 Apr. 24, 25, 1933 Jan. 18, 28, 29, 1935
Ring Sanatorium and Hospital, Inc.	Oct. 23, 1922 Mar. 11, 1925 Feb. 19, 1925 Jan. 4, 1927 Oct. 1, 1928 Oct. 25, 1929 Oct. 27, 1932 Apr. 25, 26, 1933 Apr. 25, 1934 Sept. 26, 1935
Wiswall Sanatorium	Feb. 16, 1925 Apr. 7, 1927 Oct. 16, 1929 Sept. 22, 1932 May 22, 1933 Jan. 4, 1935 Oct. 22, 1935
Westwood Lodge	Feb. 11, 1925 Mar. 28, 1927 Oct. 24, 1928 Dec. 17, 1928 Oct. 21, 1929 May 26, 1933 June 13, 1934 June 20, 1935

INSPECTIONS MADE IN RECENT YEARS — *Continued.**Private Institutions — Continued.*

NAME OF INSTITUTION.	Date.
Bosworth Hospital (opened 1933)	Nov. 6, 1933 Jan. 15, 1935 Oct. 15, 1935
Veterans Administration Facility, Northampton (opened 1924)	Sept. 23, 1924 Nov. 5, 1924 Jan. 8, 1925 Feb. 24, 1925 Nov. 20, 21, 1929 Nov. 2, 3, 1932 May 25, 1933
Veterans' Administration Facility, Bedford (opened August, 1928)	Dec. 19, 1928 Oct. 28, 1929 Oct. 17, 18, 1932 May 3, 4, 1933
Woodlawn Sanitarium	Mar. 30, 1927 May 12, 1927 July 26, 1929 Sept. 20, 1932 May 22, 1933 June 20, 1934 Oct. 10, 1935
Lila Sanatorium (licensed Sept. 10, 1937)	July 31, 1937
Dr. Frederick L. Taylor's Private Hospital	Oct. 23, 1922 Mar. 5, 1925 June 7, 1927 June 21, 1929 May 23, 1933 Dec. 20, 1934 July 9, 1935
Grove Hall Institute	Dec. 20, 1934 July 9, 1935
Washingtonian Home	Mar. 4, 1925 June 22, 1927 June 24, 1929 May 2, 1933 Nov. 13, 1934 July 25, 1935 Mar. 25, 1936
Clarke School	Oct. 15, 1929 Sept. 20, 1932 June 7, 1933 June 20, 1934 Oct. 10, 1935
Elm Hill Private School and Home for the Feeble-minded	Feb. 28, 1925 May 5, 1927 June 25, 1929 Sept. 23, 1932 May 11, 1933 Dec. 6, 1934 Sept. 4, 1936
Perkins School	Oct. 17, 1924 Mar. 26, 1925 Apr. 21, 1927 Sept. 12, 1929 Sept. 23, 1932 May 11, 1933

INSPECTIONS MADE IN RECENT YEARS — *Concluded.**Private Institutions — Concluded.*

NAME OF INSTITUTION.	Date.
Standish Manor	Nov. 3, 1922 Mar. 25, 1925 May 27, 1927 Aug. 19, 1929 Sept. 24, 1932 May 6, 1933 Dec. 27, 1934 Oct. 15, 1935
The Freer School	Mar. 1, 1922 June 28, 1927 Oct. 10, 1929 Oct. 27, 1932 Apr. 26, 1933 Apr. 30, 1934 Oct. 9, 1935

APPENDIX C.

CONSTRUCTION, MAINTENANCE AND EQUIPMENT.

In many of the hospitals crowded conditions exist, particularly for the patients. To a great extent this might have been avoided without extra cost if better planning had been used.

DESIGN OF HOSPITALS.

Many of the older institutions consist of a central building with wings attached to it. In the opinion of many of the superintendents this provides the best arrangement. It is easier to administer because those in charge have immediate access to all parts of the hospital; and it has the advantage of not compelling patients and attendants to go outside in inclement weather. It is also more economical to maintain. Doubtless there are other arrangements which have advantages of their own, and particular situations may require special treatment. But whatever the arrangement adopted, it should be clearly thought out, coherent and suited to its purpose.

Unfortunately this has not been the practice in the development of our state hospitals. Individual buildings have been added with no true relation to the rest of the hospital. In one instance, where there was plenty of land next to the main group, property was bought across a main highway, and on this a new group of buildings was erected. The superintendent said he knew of no valid reason why this had been done.

The manner in which accommodations for officers have been provided is subject to the same criticism. In one hospital the officers' quarters were placed in the administrative building, resulting in a large building of an expensive type of construction, instead of a small unit solely for administrative purposes and separate domestic quarters of a less expensive character. In other cases individual houses were built for officers, where duplex houses, such as are used in New York institutions, would have served the purpose equally well and have been less expensive to build and more economical to maintain. Unnecessarily expensive administrative buildings, service buildings and halls have also been built.

STANDARDIZATION OF HOSPITALS.

With the exception of the Schools for Feeble-minded and the Monson State Hospital for Epileptics, each hospital consists of buildings which serve similar purposes, and there is no reason why each should not have similar accommodations and equipment, and be constructed of similar material. This, however, is not the case. For example, interior finish for buildings that have similar uses varies greatly, not only in different hospitals but also in the separate parts of the same hospital. In one instance expensive tile was used in basement corridors and kitchen, and a less expensive but equally serviceable tile was used in the more frequented parts of the same building. Another example is the kitchen, bakery and canning equipment, which has been installed during the past few years with no effort at standardization. At one hospital elaborate canning machinery and expensive stainless steel sinks and tables had been installed, to be used, we were told, only five weeks a year.

Regarding purchased material, such as tableware, the same situation was found. In the cost of staff tableware prices ranged from forty-three cents to ninety-three cents per cup and saucer. A leading restaurant company in Boston uses a good type of china that costs eighteen cents per cup and saucer.

Such items as those given are mere illustrations of the waste which results from the lack of proper standards. The extra expense does not add one iota to the comfort of the patients. With proper planning and standardization additional accommodations undoubtedly could have been provided without increasing the amount which the State has paid out.

CONDITION OF BUILDINGS.

The hospital buildings, with few exceptions, are in very good condition.

The farm buildings at some institutions are in poor condition and should be rebuilt, some in different locations, and others altered and renewed to meet present standards.

The boiler plants at most institutions are in fairly good condition, although some need repairs; and in others new apparatus is required.

Many of the hospitals are close to power lines of public utility companies, some are at a considerable distance from them. Study should be made to determine whether it is more economical to run a power plant at the institution or to buy power from a public utility company; and where the institution has its own plant it is important that the best type of apparatus and most economical fuel should be used.

CONDITION OF GROUNDS.

Where buildings have recently been constructed additional landscaping is required; but with this exception the grounds at the various institutions are in good condition.

Time did not permit of anything but a superficial examination of the hospitals and grounds, but enough was disclosed to show that great savings can be made by proper planning and standardization of buildings, materials, equipment and supplies.

APPENDIX D.

RESOLVE TO PROVIDE FOR CONTINUANCE OF THE INVESTIGATION AND STUDY OF THE WHOLE SUBJECT OF THE MENTALLY DISEASED IN THEIR RELATION TO THE COMMONWEALTH, AND ALL PHASES OF THE WORK OF THE DEPARTMENT OF MENTAL DISEASES.

Resolved, That an unpaid special commission, consisting of seven persons to be appointed by the governor, is hereby established for the purpose of making an investigation and study of the whole matter of the mentally diseased in their relation to the commonwealth, including all phases of the work of the department of mental diseases, particularly as set forth in so much of the address of His Excellency, the Governor, printed as senate document number one in nineteen hundred and thirty-seven as relates to mental diseases. Said commission shall hold hearings, may require of the department of mental diseases and such other department, commission or officer of the commonwealth, as have or can obtain information in relation to the subject matter of this resolve such assistance as may be helpful in the course of its investigation and study, may require by summons the attendance and testimony of witnesses and the production of books and papers as relate to the matter under investigation, and may travel within and without the commonwealth. Said commission shall be provided with quarters in the state house or elsewhere and may expend after an appropriation has been made for legal, clerical, and other services and expenses, such sums, not exceeding, in the aggregate, dollars, as may hereafter be appropriated. Said commission shall report to the general court the results of its investigations and study

and its recommendations, if any, together with drafts of legislation necessary to carry its recommendations into effect, by filing the same with the clerk of the house of representatives not later than the first Wednesday of December in the current year.

APPENDIX E.

LEGISLATION PROPOSED IN 1938.

AN ACT ABOLISHING THE DEPARTMENT OF MENTAL DISEASES AND CREATING THE DEPARTMENT OF MENTAL HEALTH.

Be it enacted by the Senate and House of Representatives in General Court assembled, and by the authority of the same, as follows:

SECTION 1. The department of mental diseases is hereby abolished and the powers and duties of said department shall hereafter be exercised and performed by the department of mental health created by this act.

SECTION 2. The General Laws are hereby amended by striking out chapter nineteen, as amended, and inserting in place thereof the following: —

CHAPTER 19.

DEPARTMENT OF MENTAL HEALTH.

Section 1. There shall be a department of mental health, consisting of the commissioner of mental health and first and second associate commissioners. The commissioner and the first associate commissioner shall be physicians who are diplomates in psychiatry of the American Board of Psychiatry and Neurology, Incorporated, and shall have had at least seven years' experience on the staff of a state or federal hospital for mental diseases or in any equivalent psychiatric organization. The second associate commissioner, if not qualified as aforesaid, shall be a physician who has had at least seven years' experience on the staff of a hospital for general medical and surgical cases.

Section 2. Upon the expiration of the term of office of a commissioner or an associate commissioner, his successor shall be appointed for six years by the governor, with the advice and consent of the council. The commissioner shall receive such salary, not exceeding ten thousand dollars, and the associate commissioners such salaries, not exceeding ninety-five hundred dollars, as the governor and council may determine. The commissioner and associate commissioners shall be reimbursed for expenses necessarily incurred in the performance of their duties, and shall devote their entire time to the affairs of the department.

Section 3. The commissioner shall be the executive and administrative head of the department. In the event of the death, vacancy,

disability or absence of the commissioner, the associate commissioners in the order of seniority, shall perform the duties of the commissioner. The commissioner shall appoint and may remove such agents and subordinate officers as the department may deem necessary. Physicians, pathologists and psychiatrists shall be exempt from chapter thirty-one.

Section 4. The commissioner shall organize the department in divisions, including a division of hospital standards and inspection; a division of mental hygiene, statistics and research; a division of construction, equipment and maintenance; and such other divisions as he may from time to time determine, and shall assign to said divisions their functions.

Section 5. Except as otherwise provided in this chapter, directors of divisions of the department shall be appointed and may be removed by the commissioner, with the approval of at least one of the associate commissioners. The director of the division of hospital standards and inspection and the director of the division of mental hygiene, statistics and research shall each be a physician and a diplomate in psychiatry of the American Board of Psychiatry and Neurology, Incorporated.

Section 6. The commissioner, with the approval of at least one of the associate commissioners, may designate an associate commissioner to be the director of the division of hospital standards and inspection or of the division of mental hygiene, statistics and research.

SECTION 3. Section one of chapter one hundred and twenty-three of the General Laws, as appearing in the Tercentenary Edition, is hereby amended by striking out the third and fourth lines and inserting in place thereof the following:—

“Commissioner”, commissioner of mental health.

“Department”, department of mental health.

SECTION 4. Section thirteen A of said chapter one hundred and twenty-three, as so appearing, is hereby amended by inserting after the word “hygiene” in the fifth line the words:—, statistics and research,— and by inserting after the word “duties” in the sixth line the words:—, and those assigned to it as provided by section four of chapter nineteen,— so as to read as follows:— *Section 13A.* Such of the powers and duties conferred or imposed upon the department, relating to the cause and prevention of mental disease, feeble-mindedness, epilepsy and other conditions of abnormal mentality, as the commissioner may determine may be exercised and performed by the division of mental hygiene, statistics and research. In addition to said powers and duties, and those assigned to it as provided by section four of chapter nineteen, said division shall institute inquiries and investigations for the purpose of ascertaining the causes of mental disease, including epilepsy and feeble-mindedness, with a view to its prevention. It may also establish, foster and develop out-patient clinics.

SECTION 5. Section sixteen of said chapter one hundred and twenty-three, as so appearing, is hereby amended by striking out, in the fifth, sixth and seventh lines, the words "Any such patient in a state hospital may so be placed at board by the trustees thereof, and such boarder shall be deemed to be an inmate of the state hospital," — so as to read as follows: — *Section 16.* The department may place at board in a suitable family or in a place in this commonwealth or elsewhere any patient in an institution who is in the charge of the department and is quiet and not dangerous nor committed as a dipsomaniac or inebriate, nor addicted to the intemperate use of narcotics or stimulants. The cost to the commonwealth of the board of such patients supported at the public expense shall not exceed four dollars and fifty cents a week for each patient.

SECTION 6. Section sixteen A of said chapter one hundred and twenty-three, as so appearing, is hereby amended by striking out, in the first and second lines, the words " , or the trustees of state hospitals with the approval of the department", — and by striking out, in the fifth, sixth and seventh lines, the words "Any such patient in a state hospital so placed at board by the trustees thereof, shall be deemed to be an inmate of the state hospital", — so as to read as follows: — *Section 16A.* The department may place at board, under direction, in approved private homes, with provisions for occupational therapy, such patients under supervision as they believe will be benefited from a period of training therein. The number of patients so placed shall be approved by the department. The cost to the commonwealth of the board of such patients supported at the public expense shall not be limited by the amount specified in section sixteen.

SECTION 7. Said chapter one hundred and twenty-three is hereby further amended by striking out section twenty-five, as most recently amended by section four of chapter four hundred and twenty-one of the acts of nineteen hundred and thirty-five, and inserting in place thereof the following: —

Section 25. The state institutions under the control of the department shall be Worcester state hospital, Taunton state hospital, Northampton state hospital, Danvers state hospital, Grafton state hospital, Westborough state hospital, Foxborough state hospital, Medfield state hospital, Monson state hospital, Gardner state hospital, Wrentham state school, Boston state hospital, Walter E. Fernald state school, Boston psychopathic hospital, Belchertown state school, Metropolitan state hospital, and such others as may hereafter be added by authority of law.

SECTION 8. Section twenty-six of said chapter one hundred and twenty-three, as so appearing, is hereby repealed.

SECTION 9. Said chapter one hundred and twenty-three is hereby further amended by striking out section twenty-seven, as so appearing, and inserting in place thereof the following: —

Section 27. The trustees of each state hospital shall be a corporation for the purpose of taking and holding, by them and their successors, in trust for the commonwealth, any grant or devise of land, and any gift or bequest of money or other personal property, made for the use of the state hospital of which they are trustees, and for the purpose of preserving and investing the proceeds thereof in notes or bonds secured by good and sufficient mortgages or other securities, with all the powers necessary to carry said purposes into effect. They may expend any unrestricted gift or bequest, or part thereof, in the erection or alteration of buildings on land belonging to the state hospital subject to the approval of the department, but all such buildings shall belong to the state hospital and be managed as part thereof.

SECTION 10. Said chapter one hundred and twenty-three is hereby further amended by striking out section twenty-eight, as so appearing, and inserting in place thereof the two following new sections: —

Section 28. The department shall appoint for each state hospital a treasurer, who shall give bond for the faithful performance of his duties, and may remove him.

Section 28A. The department shall appoint for each state hospital a superintendent, who shall be a physician who is a diplomate in psychiatry of the American Board of Psychiatry and Neurology, Incorporated, and shall have had at least five years administrative experience in a state or federal hospital for mental diseases or an equivalent psychiatric organization. The superintendent, subject to rules made by the department, shall appoint and may remove assistant physicians and necessary subordinate officers and other persons.

A superintendent of a state hospital may be removed by the department for inefficiency, failure to perform duties properly or other good cause. A superintendent sought to be so removed shall be notified of the proposed action and shall be furnished with a copy of the reasons therefor and shall be given a hearing before the department, and be allowed to answer the charges preferred against him, either personally or by counsel.

SECTION 11. Said chapter one hundred and twenty-three is hereby further amended by striking out section twenty-nine, as so appearing, and inserting in place thereof the following: —

Section 29. (a) The trustees of each state hospital shall visit and familiarize themselves with their respective state hospitals, and may from time to time make suggestions to the department as to improvements therein, especially such as will make the administration thereof more effective, economical and humane.

(b) All trustees shall have free access to all books, records, and accounts pertaining to their respective state hospitals, and shall be admitted at all times to the buildings and premises thereof.

(c) They shall keep a record of their doings and shall record their visits to the state hospitals in a book kept there for that purpose.

They shall transmit promptly to the department a copy of the proceedings of each meeting.

(d) They may personally hear and investigate the complaints and requests of any inmate, officer or employee of the state hospital. If they deem any such matter of sufficient importance, after determining what, if anything, should be done relative thereto, they shall make written report of the determination to the department.

(e) They may at any time cause the superintendent or any officer or employee of their respective state hospital to appear before them and answer any questions or produce any books or documents relative to the state hospital.

SECTION 12. Said chapter one hundred and twenty-three is hereby further amended by striking out section thirty, as so appearing, and inserting in place thereof the following:—

Section 30. The superintendent of each state hospital subject to the rules and regulations of the department, shall cause to be given to the nurses, attendants and patients thereof instruction in such arts, crafts, manual training, kindergarten and other branches and lines of occupation as may be appropriate for the patients to undertake, especially such patients as are physically unfit to perform the usual work in or about the hospitals.

SECTION 13. Said chapter one hundred and twenty-three is hereby further amended by striking out section thirty-one, as so appearing, and inserting in place thereof the following:—

Section 31. The department shall cause all persons who are placed at board by it in families at public expense to be visited at least once in three months.

SECTION 14. Said chapter one hundred and twenty-three is hereby further amended by striking out section thirty-two, as most recently amended by chapter one hundred and fifteen of the acts of nineteen hundred and thirty-three, and inserting in place thereof the following:—

Section 32. All accounts for the maintenance of each of the state hospitals shall be approved by the superintendent thereof and shall be filed with the comptroller and shall be paid by the commonwealth. Full copies of the payrolls and bills shall be kept at each hospital.

SECTION 15. Section forty-five of said chapter one hundred and twenty-three, as so appearing, is hereby amended by striking out, in the fourth line, the word “trustees” and inserting in place thereof the word:— department, — so as to read as follows:— *Section 45.* The Walter E. Fernald state school, the Belchertown state school and the Wrentham state school shall each maintain a school department for the instruction and education of feeble-minded persons who are within the school age or who in the judgment of the department thereof are capable of being benefited by school instruction, and a custodial department for the care and custody of feeble-minded persons beyond the school age or not capable of being benefited by school instruction.

SECTION 16. Section forty-six of said chapter one hundred and twenty-three, as so appearing, is hereby amended by striking out, in the third line, the words "as the trustees shall see fit", — and by striking out, in the fourth line, the word "trustees" and inserting in place thereof the word: — department, — so as to read as follows: — *Section 46.* Persons received by the Walter E. Fernald state school, by the Belchertown state school and by the Wrentham state school shall be classified in said departments, and the department may receive and discharge pupils, and may at any time discharge any pupil or other inmate and cause him to be removed to his home.

SECTION 17. The governor, with the advice and consent of the council, shall forthwith appoint a commissioner of mental health to serve until December thirty-first, nineteen hundred and forty-three, and a first associate commissioner to serve until December thirty-first, nineteen hundred and forty-one, and a second associate commissioner to serve until December thirty-first, nineteen hundred and thirty-nine. Upon the expiration of their respective terms, their successors shall be appointed as provided in section two of this act.

SECTION 18. All unexpended balances of moneys heretofore appropriated for the department of mental diseases shall be immediately available for expenditure by the department of mental health created by this act. All furniture, equipment, papers and other property now in the possession of said department of mental diseases shall immediately pass into the possession of said department of mental health. All petitions, hearings and other proceedings pending before said department of mental diseases or any officer thereof, and all prosecutions, legal or other proceedings and investigations begun by said department of mental diseases and not completed at the time of the taking effect of this act, shall continue unabated and remain in full force and effect, notwithstanding the passage of this act, and may be completed before, by and in the name of the department of mental health. All orders, rules and regulations made by said department of mental diseases or any officer thereof which are in effect immediately prior to the time this act takes effect shall remain in full force and effect until revoked or modified in accordance with law by said department of mental health. All contracts and obligations of said department of mental diseases, in force on said effective date, shall, notwithstanding the provisions of this act, remain in full force and effect and, after said effective date, be performed by said department of mental health.

SECTION 19. The employees of said department of mental diseases who are subject to the civil service laws are hereby transferred, subject to the approval of the commissioner, to serve under the said department of mental health without impairment of their civil service status, and such employees shall retain any step increases from the minimum pay of their grade earned during their service with the said

department of mental diseases, and for retirement purposes their service with the commonwealth shall be deemed to be continuous as defined in section one of chapter thirty-two of the General Laws.

SECTION 20. The employees of the institutions, the control of which is transferred by this act from the department of mental diseases to the department of mental health, who are subject to the civil service laws are hereby transferred, subject to the approval of the commissioner of mental health, to the said department of mental health without impairment of their civil service status, and such employees shall retain any step increases from the minimum pay of their grade earned during their service with the said department of mental diseases, and for retirement purposes their service shall be deemed to be continuous as defined in section one of chapter thirty-two of the General Laws. Non-civil service employees of said institutions shall be transferred, subject to the approval of the commissioner of mental health, to the said department of mental health without any impairment of their status, and for retirement purposes their service with the commonwealth shall be deemed to be continuous as defined in said section one.

SECTION 21. The trustees of institutions, the control of which is transferred by this act from the department of mental diseases to the department of mental health, shall continue to serve as such trustees until the expiration of their respective terms notwithstanding the passage of this act, and the powers and duties of said trustees shall be restricted to the powers and duties conferred and imposed upon them, by chapter one hundred and twenty-three of the General Laws as amended, notwithstanding the provisions of any general or special law to the contrary.

SECTION 22. The eligibility requirements provided by this act for superintendents of institutions under the control of the department of mental health shall not apply to superintendents appointed under this act who were such superintendents immediately prior to the effective date thereof, and for retirement purposes their service with the commonwealth shall be deemed to be continuous as defined in section one of chapter thirty-two of the General Laws.

SECTION 23. When used in any statute, ordinance, by-law, rule or regulation the phrases "department of mental diseases" and "commissioner of mental diseases", or any words connoting the same, shall mean the department of mental health and the commissioner of mental health, respectively, unless a contrary intention clearly appears.

APPENDIX 2.

PROBLEM OF CONSTRUCTION.

A. GENERAL COMMENTS.

In studying the needs of the various institutions, each superintendent was asked to send in what in his opinion was required in his institution to increase the bed capacity for patients. In addition, there was a committee of two superintendents and an engineer of the Department, who worked out a program in accordance with requirements of the various institutions, which included not only suggestions for increasing housing facilities for patients, but also included recommendations for renovations, replacements, etc.

Our Commission has visited the thirteen mental institutions and the three feeble-minded institutions, and we have studied the buildings from the standpoint of their present use, construction and feasibility as to additions and renovations. We have also studied the suggestions made by the superintendents, and the list given by the subcommittee, which comprised two superintendents and the engineer of the Department, and also suggestions as made by the Department heads.

We have likewise visited many institutions in certain sister States, laying special emphasis on the construction problem.

B. CAPACITY OF INSTITUTIONS.

In all hospital buildings exclusive of feeble-minded schools and Bridgewater, the total capacity in accordance with the Department's allotment of space is 18,716. (There is now under construction a building at Grafton which will add 300 beds, making a total capacity of 19,016.) The total number in the hospitals, in accordance with reports made January 1, 1939, is 21,765 patients. Deducting the working capacity figured by the Department from this would show a need for 3,049 beds.

In several of the institutions the working capacity could be figured more liberally than it has been in the past, and it would

be conservative to say that the total excess at the present time, after a re-allotment, should be figured at not over 2,700.

The table in Appendix 18, showing institution population figures of January 1, 1939, should be consulted.

In the feeble-minded institutions, which includes the Belcher-town, Walter E. Fernald and Wrentham State Schools, the figured capacity is 4,003 beds. The number under care is 5,279, indicating a shortage of 1,276 beds.

The working capacities of these institutions are figured out on the same basis as the hospital buildings, and after a consultation with the various superintendents and the officials in the Department, it was agreed that the estimated shortage was excessive, and by refiguring on a more equitable basis this apparent shortage of beds could be reduced approximately 20 per cent, which would be approximately 664 beds short.

On figuring the capacities of the mental institutions and allowing for the re-allotment of space wherever possible, a conservative estimate of the number of beds needed to take care of present crowding in the hospitals for mental patients is 2,700, and the number of beds needed for feeble-minded schools is 664. Therefore it would be necessary to provide the above number of beds to take care of present patients. It is also necessary to figure on taking care of the normal increase of patients, which is approximately 400 per year.

Our Commission is not recommending increasing the capacity of the following hospitals: Boston State, Danvers, Worcester.

Any buildings recommended for the Boston State Hospital would be replacements of present wooden structures, and buildings recommended for Danvers would be to provide an admission building, which when built, and after a rearrangement is made of the working capacity, would provide adequate space for a number of patients. There is no excess of patients over the capacity at Worcester, and it will not be necessary to provide any additional space in this institution.

The Commission recommends that wherever possible the capacities of the mental hospitals be figured at 2,000. This may vary slightly over or under this figure, but we are convinced, after consultation with heads of various institutions, not only in this State but in other States, that a working capacity of 2,000 allows for economy of operation and more individual care of patients. It has been our privilege to visit certain sister States and give special study to size, capacity and

general structure of various types of institutions. We have given special study to these institutions varying in size from 1,200 beds to approximately 10,000 beds, and varying in structure from single-story buildings to nine or ten story buildings.

There are many merits to the small institution of twelve to fifteen hundred beds, but we believe in general that a two thousand bed capacity is not excessive. We feel very favorably impressed with one hospital which we visited where the majority of the buildings were of the one-story type. We believe that for general and infirmary care this is very desirable. It simplifies administration, minimizes fire risk, is conducive to good ventilation, is easy of access for visitors, and permits ready exit for out-of-door activities of the patients, many of whom, because of physical infirmities, would ordinarily be closely confined in a taller building.

In our recommendations for a building program we have figured on each institution, with the exception of Foxborough, being brought to the 2,000 capacity. The Foxborough Hospital, because of the situation and the small area owned by the institution, in our opinion, should be limited, at least temporarily, to a capacity of approximately 1,700.

In accordance with the ten-year program submitted after a survey of the space now in use, all hospitals, with the exception of the Foxborough Hospital, will have provisions for 2,000 people.

There is an average increase in the total population of the hospitals of approximately 400 per year. But this average, we have been informed, is gradually declining.

We have estimated the present shortage of beds at 2,700. A conservative estimate of the increase of patients over a five-year period, keeping in mind this gradual drop in the number added to the resident institution population each year, is 1,885. In our building program we have recommended the addition of beds in sufficient quantities to eliminate the present overcrowding, and to take care of a normal increase for the next five years, or a grand total of 4,585 beds.

This, of course, contemplates that the Department's program for boarding out of patients will in five years reach a high peak, thus easing the pressure for new beds; that means will be perfected to move out of the hospitals those custodial patients entitled to receive old age benefits now denied them because

of their residence in institutions; and that the rapid advances being made in curing mentally ill patients will result in the discharge of a substantial number of patients. These are the chief reasons why we have concentrated construction of buildings to house patients in the first five years of the ten-year building program.

In studying conditions at the feeble-minded institutions we have estimated that there is a shortage of bed space of approximately 664 in all institutions, and in accordance with our program we have planned to bring each of these institutions up to approximately 2,000 capacity by providing a total of 1,138 beds during a five-year period.

The question of a new feeble-minded institution in the eastern part of the State was considered, but it was decided that a more definite study should be made of this problem by the Department, as there are some of the present institutions which could be planned to provide for a type of patient which would not need more than custodial care. The Commission has consulted with the Department heads regarding this problem which they are studying at the present time.

The Commission has given special study to the question of psychotic children, and this is dealt with somewhat in more detail in a special section of this report. There are at the present time nearly fifty psychotic children under the age of sixteen in the various hospitals for adult psychotics, and there are more than an equal number in the various schools for the mental defectives. The Commission has felt that these children should be segregated from their present contacts and should be congregated in a unit devoted to their special care. We have spent some time in studying the care of psychotic children in some of our sister States.

As a result of our study we feel that a unit of approximately 100 beds should be established on the grounds of one of the present state hospitals, and we suggest that this be established on the grounds of the Metropolitan State Hospital.

C. FIRE PROTECTION.

For a period of many years the Department has been following a program of fire protection. From the standpoint of construction this program has been carried along the general principles of —

1. Making all new building structures of first-class construction, which means fireproof.

2. Installing fire protection measures, such as sprinklers, in buildings housing patients, with particular emphasis on wards where infirm and physically ill patients are housed; fire-resistant material on the outside of these buildings, if they are wooden structures; and the modernizing of electric wiring.

3. Gradual replacement of non-fireproof material by fireproof material in the wards housing patients.

4. By making fire departments more readily accessible to hospital service through installation of fire alarm systems.

5. By repeating the same process in buildings housing employees.

6. By repeating the same process in structures housing animals.

7. Finally, by repeating the same process in storage centers.

Without any question, all future construction should be fireproof.

A number of existing buildings at the institutions are of second-class construction. This type of construction consists of exterior brick walls, wood floors and wood partition work. In many of these buildings also there are wood stairways that are not fully protected with fireproof walls. A program of continuing to replace these wooden floors, placing fireproof stairwells at strategic points, and extending sprinkler systems should be continued. In many of the buildings the exterior walls are of brick and the corridors are of brick, lending themselves readily to remodeling for fire protection.

A central fire alarm system has been installed in some of the newer buildings and has been extended somewhat in some of the older institutions. This affords excellent protection, as it is so arranged that there is a central register in the main office where somebody is always on duty, and the alarm boxes are located throughout the various buildings at the institution. A signal from any one of these boxes notifies the central office at once as to the location of the fire, and in some instances it is directly connected with a community fire department. The installation of such fire alarm systems should be continued as far as practicable.

The items appearing for fire protection in the recommended building program refer to following out the above policy in the order enumerated.

D. CONSTRUCTION FOR HYGIENIC PURPOSES.

In all new construction it is to be expected that water supply, sewerage facilities and plumbing will be in accordance with the latest methods. The plumbing in the older buildings of a number of the institutions is in extremely poor condition. In recent years the Department has been carrying on a program of renewing and replacing antiquated plumbing. This policy should be continued.

The question of laundry facilities is likewise intimately tied up with the personal and ward hygiene of the hospitals. Several of the institutions are now carrying on laundry work under conditions which materially handicap the internal administration of those institutions. Many of the laundries are in need of much repair and are laid out in such a way that supervision of the individuals working in the laundry is not possible. Some laundries are in locations which require larger space and increased apparatus.

Laundry work is utilized by most of the hospitals as an excellent form of industrial therapy for many patients, and as each hospital has essentially the same problem in this regard it should be a comparatively simple job to plan a standard laundry and arrange for each institution to have the right type of equipment and space. We suggest from the standpoint of efficiency and proper supervision that where practicable such laundries be one-story buildings, where this is not practicable, to make every effort to confine the laundry work to a single floor. In the construction of new laundries and in the remodeling of old laundries we believe that this thought should be borne in mind.

E. FARM CONSTRUCTION.

The farm groups at the various institutions are more or less similar, but the layout and arrangements of these groups vary considerably. There are a great many buildings in connection with the farm groups which are badly in need of repairs or replacement if farming is to be continued, and at several of the institutions the farm buildings are located very close to the main group of buildings housing patients or employees. In some cases they occupy space which should be more properly adapted for extensions to the wards or the immediate service branches of the hospital. A definite program as to the

type of farm buildings and accommodations required, with a high degree of standardization of these buildings and accommodations, should be carried out.

F. BUILDINGS HOUSING EMPLOYEES.

In many institutions accommodations for employees are not adequate, in fact, in some places they live on the wards housing the patients whom they care for all day. In the detail of our building program we have made suggestions for buildings to house employees, basing these suggestions upon the customary program of the state institutions over the past ten years. The trends of the time indicate, however, that institutional employees are gradually being released from the bond of living at the institution. This policy of liberalization is commented on elsewhere in this report. From a construction standpoint we have set up in the building program the various buildings which would be needed, together with the estimated capital outlay for such buildings, if employees are continued to be housed at the institution. We would recommend, however, if employees are permitted to live in the community, that their present housing accommodations be reviewed rather carefully, with the thought in mind of turning these buildings into use for patients.

In the building program also may be found certain items calling for houses for superintendents who now live in the administration buildings of four institutions. The superintendents at the Danvers and Worcester State Hospitals live in administration buildings, intimately connected with the wards. The superintendents at the Grafton and Gardner State Hospitals live in detached administration buildings. The reorganization bill for the Department, chapter 486, Acts of 1938, does not demand that superintendents live on the grounds of the institutions. It would appear in the past that superintendents' houses have been built around a thought that superintendents would entertain the trustees and perhaps do other official entertaining in their homes. The cost of similar houses, if constructed, would depend upon the continuance or not of the policy relating to the official entertaining.

G. MISCELLANEOUS.

The Commission has given consideration to various remodeling projects, replacements and additions. Such projects require planning, more or less, as conditions arise, and vary from in-

stitution to institution. These miscellaneous projects do not lend themselves to any general comment.

We recommend a long-range building program (Appendix 3) bearing in mind the qualifying comments given above.

H. INSTITUTION FOR THE CRIMINALLY INSANE.

We recommend the erection of an institution for the criminally insane, as noted in the building program. A detail of this proposal is contained in Appendix 4, dealing with the problem of the criminally insane.

I. UNIT FOR PSYCHOTIC CHILDREN.

We recommend the erection of a special unit for psychotic children. A detail of this proposal is contained in Appendix 7, dealing with the problem of psychotic children.

J. SCHOOL FOR THE MENTALLY DEFICIENT.

The Commission has carefully studied a former proposal for a new school for the mentally deficient. We believe that such a project might become a necessity in the years to come, but that it is postponable at the moment. The detail upon which this suggestion is based will be found in Appendix 6, dealing with the problem of the mentally deficient.

K. INDIVIDUAL RECOMMENDATIONS, BY HOSPITALS.

Boston Psychopathic Hospital.

No buildings recommended.

We have been led to believe that the X-ray and operating room equipment is outdated and is totally inadequate for meeting the present needs of the hospital. The X-ray equipment is not insulated or shockproof, and provides a possible danger to those who are using it.

A program was started in replacing the windows of the seclusion rooms by modern detention windows; it would seem advisable to continue this program to include similar detention windows on the acute receiving wards and convalescent wards.

Boston State Hospital.

No new buildings recommended.

We suggest the replacement of West C and D and the A, E and F buildings. These are stucco buildings of third-class construction in which there are certain unsanitary features,

and are obsolete. It is difficult to properly heat these buildings in cold weather, and the cost of maintaining them seems excessive. In general, they have outlived their usefulness.

The hospital is bisected by Morton Street which is an active thoroughfare carrying heavy traffic. We recommend that a tunnel be constructed under Morton Street for the ready and safe passage of patients from the West Group to the East Group, where the greater part of the administrative activities are conducted.

At the present time the crossing of patients from one hospital group to the other affords not only a danger to the patient, but frequently constitutes heavy traffic tie-ups for long periods of time.

The industrial building recommended is to replace the present facilities which are in the basement of one of the medical buildings. The facilities for good industrial work are lacking in the present set-up, and likewise the electric wiring has been condemned by the Department of Public Safety. Present facilities would require considerable alteration at an expense far in excess of \$15,000 in order to make them accessible. Even then, conditions would be crowded and not too satisfactory, even though they were safe.

Sooner or later there must be some enlargement of the dining-room service in the West Group which, at the present time, is conducted under crowded and rather inadequate conditions.

The proposed project dealing with electric wiring is to place all electric wires under ground. This is in accordance with modern methods, and would eliminate the breakage of current which occasionally comes from broken wires during the heavy winter storms. Along with this project, and of special significance, is the replacement of steam lines which have been in existence for a period of some years, and which now cost considerable for yearly maintenance. We are told that corrosion causes many breaks in these lines each year, and we recommend this project purely on a basis of long-range economy.

The three officers' cottages suggested are designed to take care of married doctors. If the State is to continue a policy of providing maintenance for a resident staff we feel that it should provide adequate living accommodations whereby a certain amount of private life will be enjoyed.

The paint shop proposed is designed to replace the present accommodations which are quite inadequate, and to provide better control of the materials available in the present paint shop.

Danvers State Hospital.

In accordance with the Department allotment, the present capacity of the Danvers State Hospital is 1,861 patients. On examination it appears that with a re-allotment of space the capacity of the present institution could be increased considerably.

A receiving building, which is quite necessary in this institution, if built to accommodate 150 patients, would probably relieve most of the overcrowded conditions. This building could be built in such a manner that additions could be made at a later time, if the re-allotment of the space required a larger center. We recommend that this building be built soon. This hospital has the largest acute admission rate of any of the institutions under the Department, with the exception of the Boston Psychopathic Hospital. It serves the thickly settled and industrial district north of Boston, extending to the New Hampshire line.

The present chapel has a seating capacity of 300, and there have been repeated requests for enlarging this chapel. It is a second-class building, and something should be done to eliminate the fire hazard, and a definite decision should be made as to the proper size of chapels for all institutions, and if a capacity of 300 is too small, and there are institutions which cannot accommodate more than this, they should be enlarged. It is estimated that to enlarge the chapel will cost \$130,000.

An allotment should be made for fireproofing the first floor of the main building. This project has been started in a portion of this building, and it is estimated that it will cost \$150,000 to complete this work, and would involve wards which now accommodate nearly 600 patients. This could be spread over a period of four years.

Sprinklers have been installed in most of the main buildings and buildings which are of second-class construction. This program should be continued, and it is estimated that it would cost \$43,000 to complete sprinklers for the entire hospital. This could be spread out over a period of two or three years.

A completely new boiler plant has just been installed, but the old engines and generators are still in place. These are

very old and renewals must be made shortly. It has been estimated that to install complete new engines and generators would cost \$130,000. This program also may be spread over two years.

The present laundry is not large enough to do the work of the institution. The work room in the basement is poorly lighted and poorly ventilated, whereas the other activities are conducted on the floor above. Much of the equipment is obsolete, and the elevator is an old hydraulic lift with poor safety devices. It should be modernized either by replacement or by remodeling.

Additional hydrotherapeutic equipment for continued treatment seems necessary on both the men's and women's services. It is desired that such services be fully equipped with automatic control that would provide for more adequate treatment of the restless and agitated type of patient.

If the State is to continue to house its employees, the Danvers State Hospital should have more accommodations within the next few years. To this end we have suggested a project calling for a building for married couples.

Foxborough State Hospital.

This hospital has at the present time a population of only 1,400 patients. It is located about twenty-six miles from the center of Boston and could well be built up to a larger capacity to good advantage. The original portion of the institution has been renovated from time to time but there are still many buildings which are in very poor condition. This applies particularly to C and O buildings, and to the cafeteria and assembly buildings.

Both C and O buildings are old, of second-class construction with wooden floors, and plumbing is in very poor condition. With certain renovations, making these buildings fireproof and more sanitary, accommodations could be provided for 106 additional patients at a relatively low capital outlay.

There is need for a medical and surgical building, and the Commission recommends that a building to accommodate 325 patients be built.

The present kitchen and dining-room accommodations are quite inadequate and cannot accommodate even the present population. A complete remodeling, with increase in size of the present cafeteria, should be completed before long, and is certainly a prerequisite to any appreciable increase in patients.

The fire protection program already inaugurated should be carried on as rapidly as possible.

The various wards would, of course, be remodeled so as to be fireproof, but the extension of sprinklers in the wooden cottages occupied by employees, and in certain of the farm buildings, should be completed. A fire alarm system is most desirable.

The garage and equipment recommended are designed to provide facilities for putting under cover a large amount of motor vehicle equipment and farm equipment which is now left out of doors in all kinds of weather. This building would also provide for a repair shop for motor vehicle equipment.

It seems advisable to eventually consider the purchase of more land at the Foxborough State Hospital, particularly that section which runs along the southern boundary of the property of the hospital, and which would provide the hospital with an opportunity to request the closing of the public thoroughfare, — Chestnut Street.

It is suggested that the old assembly hall, which has been abandoned so far as its original purposes are concerned, be remodeled and made into an adequate vegetable storage building, with the possibility of adding facilities for canning. The present vegetable storage facilities are quite inadequate, and the remodeling of this old assembly building seems to be a feasible project.

Gardner State Hospital.

The central building at the Valley Farm Group at this hospital is of wooden construction and has been condemned for a period of years, and should be modernized, either by replacement or remodeling.

Many of the Colony buildings at Gardner are old wooden structures. Some are close to one hundred years old. Several of them have been condemned.

For many years this hospital was considered a transfer hospital. In recent years it has been utilized as a receiving hospital, and the general type of patient is changing from those who are well institutionalized to a more active group. In the future program of the hospital should be added an admission building and hospital building for both men and women patients.

Continuation of fire protection program in buildings housing patients should be made.

The hospital at the present time is approximately 20 per cent overcrowded, and not only should this overcrowding not increase, but there should be some reduction in it. The building of an additional colony group for one hundred patients is suggested, such construction to be of simple type and relatively low cost.

The question of a superintendent's house is dependent upon the general policy to be adopted relative to the responsibility of superintendents. In this instance the superintendent lives in the administration building, which is crowded with administrative offices and employees' quarters, but is not complicated by having wards for patients in the immediate proximity. The present living accommodations for the superintendent are not conducive to privacy nor to the freedom from interruption of the continual patient problems which are bound to come to the administrator who actually lives in a part of the hospital proper.

A suggestion for additional cottages for physicians is prompted by the unsatisfactory living accommodations for married physicians at the Gardner State Hospital at the present time. As a general policy it seems proper that physicians and their families should be comfortably housed and somewhat removed from the daily contact with their work. Additional consideration must be given to the families of physicians if continued service of the latter is to be expected.

If the State is to continue the policy of housing employees, this hospital, within the next few years, will require additional accommodations for employees. The recommended project for an employees' building is designed to cover this need within the next few years.

A new central building at the Wachusett Colony is designed to further relieve some of the crowding and to take care of some of the future anticipated patients.

Grafton State Hospital.

The present population at this hospital is approximately 1,550, and a new building to house 300 additional patients will be opened during the calendar year of 1939.

The present laundry facilities are barely adequate to take care of the present population, and a new laundry should be built to properly take care of the needs in the immediate years to come.

By the end of the current year the women's section (Pines) will be fairly complete. We recommend a similar ward and service addition for the men's group (Elms).

Additions to the storehouse and bakery equipment will be necessary to properly meet the needs of the hospital after the current year.

Eventually sun porches should be added to both the men's and women's infirmary buildings.

Eventually sun porches should be added to the women's acute receiving buildings identified as Pines B and C, and to the men's infirmary building, identified as Elms B and C.

Within the next year the present Pines service building will be vacated, and this service taken over by the new building which is now under construction. For the relatively small sum of \$25,000 the present Pines service building could be changed into a new women's admission building, housing 50 patients, and we recommend this procedure.

The present tunnel between Pines E and the new service building under construction is small and narrow and carries steam lines. By the addition of a new tunnel it would be possible to route patient traffic indoors so that it would be unnecessary for patients to go out of doors in inclement weather in passing to the service building for meals. This project should be carried out.

At the present time the patients in the Willows Group (female) have to cross a public highway for their meals, and we suggest a passageway from this group to the service building.

As additions to the hospital are made it will be necessary to have additional heating facilities, and a new building is provided in the building program for this purpose.

Grafton is another hospital in which the superintendent resides in the administration building, which is crowded with various administrative offices and with other quarters for employees. Provisions are made in the building program for construction of a superintendent's house whereby the superintendent might be permitted to be relieved, in his home life, from the immediate contact and anxieties of his daily duties. This, we believe, is a suggestion which will lead to increased contentment and efficiency. The present superintendent's quarters would be available for other urgent administrative purposes.

Two officers' cottages or possibly a duplex house for two physicians' families, are recommended in order to make more

suitable accommodations for married physicians, and in order to attract the type of physicians whom the State would like to have in continued service.

If the State is to continue its program for maintaining employees, the Grafton State Hospital should be provided with additional facilities for housing such employees, and we have proposed a building to accommodate married couples.

Medfield State Hospital.

For a period of many years this hospital was considered essentially a transfer hospital. In recent years it has assumed the function of an acute receiving hospital, serving as one of the outlets for the thickly settled metropolitan area. The construction of the hospital has not kept pace with the changing functions of the hospital. The majority of the buildings are two-story buildings and have had inadequate fire protection. A program of correcting this deficiency has been in progress during the past few years, and should be continued at as rapid a pace as possible.

Most of the plumbing throughout the various ward buildings has been unsanitary and obsolete. Some progress has been made in recent years towards rectifying this condition, and the program of replacing the plumbing should continue without interruption.

In view of the changing functions of the hospital, an acute receiving building and a building for disturbed men, as well as one for disturbed women, should be added in the not too distant future.

It would appear that the present Infirmary was designed around the thought of giving care only to employees and to those patients who required major surgical operations. The rooms for such employees or patients, as the case may be, are on the second floor, with an operating room and other facilities on the first floor. There is no elevator service available. There should be a modernization of this Infirmary, with an addition whereby the greater portion of the physically ill patients might be congregated and medical service for them concentrated in this building. We feel that this change is urgent.

The layout of the buildings at Medfield lend themselves very readily to being connected by corridors. At the present time they are completely separated and have to be administered as more or less individual units. Problems coincident to the

administration of this hospital would be greatly diminished by the addition of connecting corridors.

We are recommending the reconstruction of the present employees' dining room into an employees' cafeteria, primarily on the behalf of increased service and increased efficiency, together with the economy and diminution of table waste that are consistent with such service. This is designed to serve 350 people per meal.

A project is included to renovate the present pantries, of which building changes approximate one half of the proposed expenditure and new equipment the other half. The present location of the general dining rooms for approximately 1,000 patients is such that separate scullery and dish-washing pantries are necessary for the men's and women's sections. The proposal is to renovate these sections, putting in waterproof floors and side walls, minimizing the vermin problem, and replacing obsolete equipment with new.

A new shop and industrial building is proposed to replace the present inadequate quarters which have repeatedly been condemned by the Department of Public Safety. Equipment is now housed in the basements of certain ward buildings and constitutes a fire hazard. It is expected that all hospital industries will be moved to the new building, and that the present site of these industries will be renovated and made safe for the centralization of the occupational therapy rooms.

The Medfield State Hospital has been seriously handicapped in recent years in obtaining proper medical personnel through inadequate facilities for the housing of married doctors. Proposal is made for two officers' cottages which should be completed to meet this need within the next few years.

During the next few years serious consideration should be given to the erection of a new administration building. The present administration building is inadequate, poorly arranged, is not fireproof, and the facilities for administrative purposes, storing of records, etc., are very poor. Just as soon as the immediate patient needs are taken care of this administration building should be provided.

Metropolitan State Hospital.

This is the newest hospital from the standpoint of construction. It is not as yet completely built, and is not equipped to care for all types of patients. At the present time it is considered

a transfer hospital only. A receiving building should be added at an early date, so that this hospital can assume the functions of a receiving hospital and relieve the pressure for admissions in the metropolitan area.

In the future development, provisions should be made for a building for disturbed men and one for disturbed women.

It is on the grounds of the Metropolitan State Hospital that we recommend a building be placed for psychotic children, a detail of which is discussed elsewhere in this report.

As the hospital grows there should be provided a shop building for the usual hospital industries; also, after the addition of the new proposed buildings, there should be some definite effort put into completing the landscaping and regrading of the grounds around the building. There has already been some work done along this line which has added materially to the appearance of the grounds around the Metropolitan State Hospital. This should be carried on after the final placing of new buildings is made.

Northampton State Hospital.

A program for fireproofing the main group of buildings at this institution should be continued.

The main farm group is now located close to the male wards and the new kitchen and cafeteria units. The buildings are of wood construction and form both a fire and health menace. A development is proposed for a new farm group, including a new farm dormitory for 100 patients, a barn group and dairy group, situated some distance from the main hospital group. This program should be started relatively soon.

Northampton State Hospital serves a large western section of the State and is located 60 miles from the nearest public hospital for psychotic adults. This hospital, therefore, has to be rather complete in itself and cannot depend too much on service from other state hospitals. Adequate provisions should be made for the proper care of patients suffering from tuberculosis. A new building for these patients is recommended. We suggest that this building be placed in the vicinity of the present farm group after the latter has been developed under the new proposal.

In the building program we have provided for additional ward buildings. These are designed to take care of some of the present overcrowding which is 17 per cent, also to elimi-

nate the necessity of transferring patients from Northampton to hospitals not remotely situated from their homes. We would again point out that the Northampton State Hospital serves a large section of the State, and the nearest other hospital for adult psychotic patients is 60 miles away.

This hospital should be provided with an additional turbine and generator. Several times within recent years the hospital has been without electric current, due to flood conditions, and there should be available another emergency machine.

A new bath house is suggested so that provisions may be made for central bathing of all patients who are able to be up and about. At the present time bathing facilities are quite inadequate, and are contained on the individual wards. It is our feeling that this does not represent optimum efficiency and is not particularly economical.

The proposed addition to the women's nurses' home is made contingent upon the policy of the State relative to housing employees.

Taunton State Hospital.

This hospital at the present time has a resident population of approximately 1,660 patients. It serves the large Cape area, extending as far as Provincetown. The hospital is not able to care for the demands for new admissions coming from its own district, and many of these patients have to be transferred to other hospitals a long distance from the homes of friends and relatives. We believe that Taunton State Hospital should ultimately be developed so as to care for the greater part of these patients, and eliminate the long traveling distance for friends and relatives. Additional patient facilities recommended in the building program are designed with this thought in mind. Among these are the proposed male Infirmary and the psychiatric or admission building, which are designed to be added to the new group of buildings which were added during the past few years. The present facilities for the care of tuberculosis and many of the acute type of patients are not adequate.

Much progress has been made in recent years in renovating the obsolete plumbing in the main group of buildings. This should be continued until all such plumbing is modernized.

The present laundry at Taunton is a two-story structure and is inadequate for the present demands made upon it. It should be replaced.

It is proposed to add a new kitchen and dining room building for the new hospital group, such building to be of fireproof construction and to accommodate the service facilities for this new hospital group. At the present time the service facilities are in the main section of the hospital some distance away, and service forms a most difficult and not too satisfactory administrative problem.

After an addition to the present fire-protection program, we are proposing extension of the present fire alarm system throughout the hospital.

We are including a project calling for placing electric wires completely under ground, changing the wires in the hospital, which are now run in wooden moldings, and making certain necessary changes in the power plant, so that the hospital may generate all of its own electricity. It is not thought that such a procedure would require any additional personnel, and it seems to be an economical proposal.

A greenhouse is proposed as a future development to replace the present greenhouse which is now becoming rather obsolete, and is located in the proposed way of future developments. The hospital is rather reluctant to even think of giving up its greenhouse activities, and the replacement of present facilities is desirable within the next few years.

Two officers' cottages are proposed which are designed to be of double cottage type, and by this means it is hoped to attract, accommodate and hold for continued service a high grade of medical personnel.

During the recent development of the Taunton State Hospital the newer buildings have been laid out with a plan in mind to change the entrance to the institution from its present inconvenient site to the Bay Street end. Some progress has been made in this respect by making a dam in the river, with abutments for a bridge. The proposal offered in the building program is to purchase certain pieces of real estate and to continue the roads and sidewalks for this entrance. Eventually a new administration building would be placed close to this entrance, which is much nearer to the main line of traffic and would eliminate the necessity of auto traffic approaching the wards for patients, except when such cars had immediate business at the wards.

A new farm dormitory is proposed at one of the colonies in order to accommodate more patients who may be occupied in farm activities.

We are also proposing a new root cellar as an eventual development for the more adequate storage of home-grown vegetables.

Westborough State Hospital.

Under the auspices of the Federal grants this hospital has been provided with storage facilities, kitchen, dining room, laundry, and other service facilities, for a patient population of 2,000. It now has a resident population of approximately 1,575 patients. It could be built up to a 2,000-bed hospital with less capital outlay than would be the case in other institutions where the service facilities would have to be increased.

The present power plant, however, is old and is showing considerable need of repair or replacement. It undoubtedly will have to be replaced within the next three or four years, irrespective of additional resident population. We believe that a detailed study of the efficiency of this plant would indicate the need of a new plant in the near future. The generating equipment is insufficient for the hospital requirements at the present time, and it is necessary to purchase a portion of the electricity used.

The main administration building is an old structure which has outlived the usefulness of its original purpose. A certain section of it could be remodeled so as to accommodate 300 additional patients, and we believe this is the economical thing to do.

The dairy group is now located on various sections of the hospital grounds. Many of the buildings are old wooden structures which are quite dilapidated and need to be replaced. In the replacing of this group we suggest that from the standpoint of efficiency the group be centralized near the farm activities.

A new admission building is suggested because of the service facilities already available, and because of the fact that this hospital receives a large number of acute admissions not only from the immediate vicinity of Westborough, but also from the thickly settled metropolitan area just west of Boston proper.

In the future development a building for disturbed women patients should be provided, complete with special dining facilities.

In our building program we have recommended remodeling the old store building which was replaced when new storage facilities were made available two or three years ago. However, in view of the fact that this building was severely dam-

aged during the storm last fall, we feel it inadvisable to attempt to reconstruct it.

Provisions are made in the building program for three officers' cottages designed for married physicians. The need for such accommodations has been dwelt upon repeatedly.

Worcester State Hospital.

No additional bed space is recommended for this hospital.

We do feel, however, that the fire protection program (replacing wooden floors, completion of rewiring, installation of fire alarm system, extension of sprinklers, etc.) which has been started should continue to completion as rapidly as possible and without interruption.

The present laundry is inadequate for the needs of the hospital and working conditions for both patients and employees are far from ideal. From both the humanitarian and economical point of view this should be replaced at an early date.

The male wards of the main building have been without proper porches for several years, and we feel that these additions should be made in the not too distant future.

The wards for acute medical and surgical cases have been functioning efficiently over a period of years. They are, however, without an elevator, and the wards as a whole should be modernized. We recommend the renovation of these wards.

Cooking and feeding facilities in the Summer Street branch, housing over 500 patients, require complete renovation. A modern kitchen and cafeteria are recommended.

Under the present plans it is proposed to remodel the present laundry into a storeroom, after a new laundry has been provided. This is set up in the building program for consideration in the immediate years to come.

Provision is also made for central bathing facilities and additional hydrotherapeutic facilities on the men's wards, such equipment to more or less duplicate that which has been in existence on the women's wards during the last few years.

We suggest a project putting an additional wing onto the present cow barn in the main hospital group which would provide concentration of the milking herd in one place, saving the cost of transportation of milk, and providing better control of the production and distribution of milk.

In the next few years it would be most desirable to provide better accommodations for patients employed in industrial workshops in the hospital, and we would propose an industrial building. The present shops are inadequate, the working conditions poor, and they do not provide for adequate patient supervision.

The superintendent at the Worcester State Hospital resides in an apartment in the administration building immediately adjacent to wards housing patients. We feel that this provides an extremely difficult mode of living for a superintendent, and we suggest the erection of a superintendent's house on the grounds of the hospital, as a building project to be considered immediately after the patient needs have been completed.

Monson State Hospital.

This hospital is the only public hospital in the State devoted for the sole care of both psychotic and non-psychotic patients suffering from epilepsy. The pressure for admissions is heavy, and there is a relatively long waiting list. Ward additions and infirmaries should be made at a very early date. The present resident population at Monson is approximately 1,450, and in our building program we are recommending the addition of 500-odd beds.

The program of fire protection and fire prevention already inaugurated should continue.

In some of the older buildings a great deal of the plumbing is obsolete and unsanitary. This should be replaced as rapidly as possible.

We also recommend the addition of a new assembly building. The present facilities for such purposes are located on the second floor of the old kitchen building. This does not provide sufficient space, and it likewise is undesirable to bring a large number of epileptic patients together on the second floor of a building with the type of egress that exists.

Eventually it will be necessary to provide for new laundry facilities, especially as patient population increases; also, as the size of the hospital increases, it will be necessary to provide adequate facilities for industrial therapy among the patients, and this is suggested in the construction program.

The question of adding officers' cottages depends upon the state policy relative to housing such employees on the grounds. At the present time certain staff members reside in the adminis-

tration building. This is inconvenient for proper living quarters, and it also takes away valuable space which should be utilized for administrative purposes.

If farming activities are to be continued it is suggested that serious consideration be given to the proposal for additional land purchase of four parcels which are either adjoining to or completely surrounded by the present state property at the Monson State Hospital.

Belchertown State School.

This institution has a resident population of approximately only 1,300 patients. Contingent upon any ward additions, there would have to be added another boiler and an extension to the boiler house. The waiting list for mental defectives at this school is so long and the pressure for their admission so great that we feel additional ward buildings to this institution should be made in the near future. If the hospital is to be later developed into a 2,000-bed institution, additional steam, water and sewerage facilities will be required. All recommended additions have been made with a view to increasing this school to 2,000-bed capacity.

Two officers' cottages are recommended for the steward and a staff physician. The school officials feel very keenly about the question of continuing to have the families of hospital officers living in the hospital buildings.

The question of additional buildings for employees would depend upon a general policy of housing employees on the institution grounds.

Walter E. Fernald State School.

The construction problem here resolves itself into facilities for the care of additional patients, due to the long waiting list and pressure for admissions. An additional building to the school was planned in 1938, but the plans were abandoned when funds did not become available. We have studied the question as to increasing the size of the lowest cost buildings at Templeton Colony, connected with this school, and have commented on that in the section dealing with the care of mental defectives. We have not included this in our building program because such a proposal would depend upon the future policy of the Department in regard to the transfer of adult patients away from the school.

Eventually with the enlargement of the hospital some addition will be necessary to extend the present power and heating facilities.

It is proposed to revamp the present old recreation building and concentrate the laboratory services for research purposes in this unit.

It is suggested that the old administration building be remodeled and put into active use for living accommodations for employees.

Two officers' cottages are recommended for staff physicians with families.

It is suggested that additional wings be added to the present industrial building so that all of the school industries may be concentrated, and also for the purpose of doing away with the present unsatisfactory industrial conditions which exist in some of the basement rooms. Recommendations to abandon some of these latter rooms have been made by the Department of Public Safety.

The program for fire prevention should be continued. A great deal of additional work in this line is necessary, particularly at the Templeton Colony.

Wrentham State School.

The building program here is also recommended on the basis of the long waiting list and pressure for admissions.

The present power plant is inadequate for the needs of the hospital at this time, and has been the subject of official comment over a period of years. A new power plant is most certainly a prerequisite to any program calling for additional buildings. The newest boiler is over twenty years old, and the generating equipment is entirely outdated.

Within the next few years the Wrentham State School should be provided with adequate gymnasium facilities. At the present time such facilities are cramped, small rooms in the school building are used, and floor space is not sufficient for any large gathering or to organize groups for special recreational activities. Gymnasium and recreational activities form a distinct part in the program of therapy in a school for mental defectives.

After a new gymnasium has been provided it would be possible to remodel the present schoolhouse and have additional schoolrooms for extra class work.

There should be a second floor added to the storehouse. The school administration is handicapped by cramped accommodations at the present time, and certainly will require an addition as the size of the school increases.

Some attention should be given to renewing the surface on the present filter beds. We are informed that these are filtering improperly and that they should be resurfaced and the drain pipe replaced. This certainly is a necessary prerequisite before any appreciable increase in size can be made to the school.

During the next few years there should be an addition to the present clinical building whereby patients requiring close observation and study would be readily accessible.

Officers' cottages are necessary to provide proper living accommodations for those key individuals in the institution who have families.

A 10 YEAR BUILDING PROGRAM FOR DEPARTMENT OF MENTAL HEALTH COMMONWEALTH of MASSACHUSETTS																														
SUBMITTED BY SPECIAL COMMISSION ON MENTAL DISEASES,																														
	1939			1940			1941			1942			1943			1944			1945			1946			1947			1948		
INSTITUTION	PROJECT	BEDS	AMOUNT	PROJECT	BEDS	AMOUNT	PROJECT	BEDS	AMOUNT	PROJECT	BEDS	AMOUNT	PROJECT	BEDS	AMOUNT	PROJECT	BEDS	AMOUNT	PROJECT	BEDS	AMOUNT	PROJECT	BEDS	AMOUNT	PROJECT	BEDS	AMOUNT	PROJECT	BEDS	AMOUNT
BOSTON PSYCHOPATHIC	X-RAY EQUIPMENT		10,000							DETENTION WINDOWS		23,000																		
BOSTON STATE	TUNNEL		30,000				REPLACE WEST C & D.		450,000	INDUSTRIAL BLDG.		40,000				REPLACE A-E-F		600,000	PAINT SHOP		16,000	ENLARGE WEST DINING ROOM ELEC. WIRES UNDER GROUND, NEW ST. LINES		30,000			3 OFF COTTAGES		45,000	
DANVERS	ADMISSION BLDG. ADD. TO LAUNDRY BLDG. & EQUIP.	150	350,000 95,000	FIREPROOFING		75,000	NEW ENGINES & GENERATORS		130,000	FIREPROOFING		75,000				CONT. BATHS MARRIED COUPLES HOME	84	73,000 150,000	COMP. SPRINKLERS RENOV. REAR CENTER & CHAPEL		43,000 140,000									
FOXBOROUGH	REMODEL C BLDG	76	50,000	MED. & SURGICAL BLDG.	325	750,000	REMODEL "O" BLDG	30	115,000				REMODEL CAFETERIA		150,000	REMODEL ASSEMBLY BLDG. SPRINKLERS FIRE ALARM SYS.		10,000 10,000 20,000	GARAGE & EQUIP.		13,000	PURCHASE LAND		10,650						
GARDNER				CENTRAL BLDG. VALLEY	100	85,000				ADMISSION BLDG. NEW COLONY GROUP	100	250,000 110,000	HOSP. BLDG. FEM. CENTRAL BLDG. WACHUSSETT	86 100	175,000 85,000	HOSP. BLDG. MALE	86	175,000				SPRINKLERS 2 OFF COTTAGES		52,500 20,000	EMP. BLDG.		100,000	SUPT. HOUSE		20,000
GRAFTON	CHANGE PIPE SERVICE TO ADMISS. BLDG.	50	25,000							WARD BLDG. & SERVICE - ELMS	300	600,000	BLDG. FOR MARRIED COUPLES.	84	150,000	LAUNDRY BLDG. & EQUIP.		100,000	TUNNEL PIPES "E" TO NEW SERV. BLDG. ADD. BOILER. ADD. TO STOREHOUSE BAKERY & EQUIP. ROVERS		9,000 10,000 50,000 15,000	SUN PORCHES PINES B & C.		28,000	SUPT. HOUSE 2 OFF COTTAGES		20,000 20,000	SUNPORCHES ELMS B & C. PASS. WILLOWS BLDG. TO SERVICE BLDG.		28,000 16,575
MEDFIELD	DIST. BLDG. MALE & FEMALE	140	229,000				ACUTE BLDG	160	325,000	RENEW TOILETS & BATHS ADD. TO INFIRMARY	160	50,000 275,000	CONN. CORRIDORS FIRE PROTECTION		75,000 70,000	FIRE PROTECTION		70,000	SHOP BLDG. & INDUSTRIAL BLDG.		141,000	ADMINISTRATION BLDG. & RENOV. EMP. CAFETERIA		150,000 11,000	RENOVATE PANTRIES		12,000	2 OFF COTTAGES		25,000
METROPOLITAN.	CHILD PSYCHIATRIC	100	300,000	RECEPTION BLDG	150	400,000				DIST. BLDG. MALE	200	350,000	DIST. BLDG. FEM.	200	380,000				SHOP BUILDING		36,000				LANDSCAPING & GRADING		25,000			
NORTHAMPTON				FARM DORMITORY ADD. TO INFIRMARY	100 75	185,000 60,000	WARD BLDG.	150	230,000	T. B. BLDG.	75	175,000	WARD BLDG.	150	230,000	FIREPROOF MAIN GROUP		40,000	FIREPROOF MAIN GROUP DAIRY GROUP TURBINE & GEN.		40,000 80,000 21,000	FIREPROOF MAIN GROUP BATH HOUSE ADD. NURSES HOME		40,000 27,000 85,000	FIREPROOF MAIN GROUP		40,000	DAIRY BARN		15,000
TAUNTON	LAUNDRY BLDG. & EQUIP.		110,000	FARM DORMITORY RAYNHAM	50	135,000	MALE INFIRMARY	200	425,000				PSYCHIATRIC BLDG.	150	400,000				KIT. & DIN. RM. } GROUP BAY STREET ENT. FIRE ALARM SYS. GEN. & REWIRING		80,000 70,000 25,000 88,000	RENOVATE TOILETS & BATHS		47,500	ROOT CELLAR GREEN HOUSE 2 OFF COTTAGES		17,000 10,000 26,000			
WESTBOROUGH				POWER PLANT		250,000	ADMISSION BLDG.	220	500,000				DISTURBED BLDG.	200	350,000	REMODEL ADMINISTRATION BLDG. & WARDS —	300	600,000	DAIRY GROUP REMODEL OLD STORE BLDG.		80,000 30,000	3 OFF COTTAGES		37,500						
WORCESTER	LAUNDRY BLDG. & EQUIP.		150,000							FIREPROOF 1ST. FL. STORE HOUSE		75,000 75,000	FIREPROOFING NEW MALE BATH HOUSE		75,000 80,000	RENOV. KITCHEN & DIN. RM. SUMMER ST. INDUSTRIAL BLDG. FIREPROOFING COMP. REWIRING		125,000 40,000 75,000 50,000	PORCHES - QUIMBY & SALISBURY COMP. FIRE ALARM CONC. FLS. - WASHBURN DAIRY BARN NEW LBS. SUMMER ST.		50,000 10,000 32,000 18,000	RENOVATE THAYER & FOLSOM		35,000	SUPT. HOUSE		20,000			
MONSON	WARD & INFIRMARY RENOV. PLUMBING & FIRE PROTECTION	116	175,000 25,000	WARD & INFIRMARY RENOV. PLUMBING & FIRE PROTECTION	150	200,000 25,000				WOMENS BLDG.	120	180,000	MENS BLDG.	120	180,000	ADD. TO HOSPITAL	30	60,000	ASSEMBLY BLDG.		150,000	LAUNDRY BLDG. & EQUIPMENT		40,000	INDUSTRIAL BLDG. REMODEL OLD KITCHEN PURCHASE LAND.		40,000 34,000 22,000	2 OFF COTTAGES		25,000
SUB-TOTAL		732	1,549,000		950	2,165,000		760	2,075,000		1055	2,278,000		1090	2,400,000		500	2,198,000		—	1,254,000		—	735,650		386,000			174,575	
BELCHERTOWN	INFIRMARY POWER PLANT	230	250,000 40,000	BOYS DORMITORY CONTAGIOUS HOSP.	110 30	125,000 50,000				GIRLS DORMITORY	110	125,000	ADD. TO HOSPITAL	60	75,000				STEAM, WATER & SEWER. FACILITIES		37,000				2 OFF COTTAGES		20,000	4 EMP. COTTAGES		120,000
W. E. FERNALD	GIRLS INFIRMARY	100	160,000	BOYS DORMITORY	110	125,000	REMODEL RECEPTION BLDG. & HOSPITAL GIRLS DORMITORY	50 110	125,000 125,000							EXT. POWER & HEATING		60,000	REMODEL OLD ADD. BLDG. REMODEL REC. BLDG. FIRE PROTECTION WINGS. IND. BLDG.		20,000 15,000 38,000 70,000					2 OFF COTTAGES		25,000		
WRENTHAM	INFIRMARY POWER PLANT	116	175,000 225,000				HOSPITAL BLDG.	100	225,000							SCHOOL & GYM. ADD. TO HOSPITAL	12	140,000 12,000	RENEW SEWER BEDS		39,000	ADD. TO CLINICAL BLDG. REMODEL ADM. BLDG. REMODEL SCHOOL		50,000 18,000 10,000	ADD. TO STOREHOUSE		30,000	3 OFF COTTAGES		37,500
SUB-TOTAL		446	850,000		250	300,000		260	475,000		110	125,000		60	75,000		12	212,000		—	219,000		—	78,000		—	50,000			182,500
GRAND TOTAL		1178	2,399,000		1200	2,465,000		1020	2,550,000		1165	2,403,000		1150	2,475,000		512	2,410,000		—	1,473,000		—	813,600		—	436,000			357,075

INSTITUTION FOR CRIMINAL INSANE		500	1,730,000																											
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APPENDIX 4.

PROBLEM OF THE CRIMINALLY INSANE.

In our 1937 report we stated that the Legislature had passed enabling legislation for the erection of a state hospital for the care of the criminally insane on land owned by the Norfolk Prison Colony, and that while we had given much consideration to the problem of the criminally insane, we did not have sufficient time, because of the pressure of other matters before us, to reach a decision as to whether we should approve such a location, even though the site is favored by many interested persons.

A separate hospital for the criminally insane has long been sought. Dr. L. Vernon Briggs, at one time a member of this Commission, suggested such a hospital while he was a member of the State Board of Insanity in 1913. Francis B. Sayre, former State Commissioner of Correction, urged that the Department of Mental Diseases take over the care of the criminally insane. His successor, Dr. A. Warren Stearns, formerly an associate commissioner of mental diseases, approved the idea. In recent times, Arthur T. Lyman, present Commissioner of Correction, and James A. Warren, superintendent of the Bridgewater State Farm, where the criminally insane are housed, have strongly urged that these unfortunates be transferred to the Department of Mental Diseases.

The term "criminally insane" is misused in regard to many of the patients in the state hospital department of the Bridgewater State Farm. Many are confined there who have never been convicted of any crime. Others never have been arrested, having been transferred from other hospitals where they were regularly committed for mental diseases.

If homicide or other crime is attributable to the mental disease of the patient, he is not a criminal. In fact, in certain offences, the law directs that a mental examination be made prior to trial, and, if the person be found mentally incompetent,

he is sent to Bridgewater without further delay and never comes to trial while in that condition.

A person convicted of a crime while mentally normal, and who afterwards becomes insane while serving sentence, is a sick man as well as a criminal, and should be given hospital care and treatment for disease just as he would for any other ailment he contracted.

We find at the state hospital department at Bridgewater State Farm that patients belonging to both these classes are branded as "criminally insane." They are cared for entirely as prisoners; the problem is necessarily custodial and not medical to the officials there. The medical care and treatment is limited to periodic, usually annual, physical and mental examinations, the results of which are recorded in the patient's case record, and such emergency treatment for injuries and intercurrent disease as may be necessary.

We find that no attempt is made whatever to use recognized forms of treatment for mental disease as such.

There are no hydrotherapy, no occupational therapy, no psychotherapy, and none of the other methods of counteracting or quieting the disturbance of disturbed patients.

It is true that many of the patients are of the most serious type as regards danger to the lives, health or property of others, but since they are patients through no fault of their own, and since the State has adopted the policy of assuming full responsibility for the care of the mentally ill, they should receive the medical care and treatment that is available to other patients suffering from similar diseases in other state hospitals.

Our investigations have shown us that there are a number of patients in the hospitals under the Department of Mental Health who have similar tendencies to violence. They receive, however, more adequate medical psychiatric attention and treatment. Seldom do they attempt a violent act, and rarely do they succeed. We are convinced that these attempts to commit acts of violence are less frequent and less serious by far than they would be if the patients did not receive the psychiatric treatment now denied those at Bridgewater.

There is a tendency on the part of the public to become fearful of patients who are harmless and who are granted a certain amount of liberty during the day, which they value highly. Such liberty is part of the psychiatric treatment. It encourages the patient to assume as much responsibility as possible, fosters self-respect and self-restraint, and brings him

in pleasant association with persons in the neighborhood living normal family and community lives.

The vast majority of people living in the neighborhood of state hospitals have no fear of these patients, but, on the contrary, are inclined to welcome their presence at community recreations. They are willing in this respect to contribute their part to the restoration of the mental faculties of the patients.

A small minority have always objected to this liberty and have demanded that it be restricted. They have referred to these patients as "homicidal maniacs," who have permission to wander at will around the countryside. Their objections have made the patients restless and resentful, with detrimental results to their morale and their prospects for improvement and recovery.

There are several advantages to be gained by the erection of a hospital for the criminally insane.

It has become quite obvious that the problem of the criminally insane is primarily a medical problem rather than a correctional one, but likewise a medical problem in which a high degree of segregation, and security of segregation, must be maintained.

With the removal of the criminally insane from Bridgewater to a new institution under the Department of Mental Health, the present Bridgewater facilities would become available, with some remodeling, for the care of a much larger number of defective delinquents from the schools for the mentally deficient, and would, in a measure, relieve the present long waiting list. Because of the lack of proper facilities in the Department of Correction, the schools have, by necessity, continued to care for many of this type. The defective delinquent problem is more clearly a correctional one, and the dangers coincidental to intermingling this class with the non-delinquent feeble-minded are obvious.

It thus is apparent that the "bottle neck" which is hampering progress in two large state departments is the present lack of proper care and segregation of the criminally insane. The Commission has given this problem considerable study and has put forth special effort to visit a sister State to study the most modern methods of care and construction of a hospital for the criminally insane.

Last year a representative of the Commission appeared before the ways and means committee to advocate the erection

of a 500-bed hospital for the criminally insane at a cost not to exceed \$1,700,000. Unfortunately nothing was done at that time. We wish to reiterate our recommendation for the early erection of such a hospital on state-owned land near the Norfolk Prison Colony, and the transfer to the hospital of criminally insane patients at the Bridgewater State Farm. The hospital would be under the supervision of the Department of Mental Health, which could then transfer from the present state hospitals to the proposed state hospital those patients who have tendencies to violence, etc.

The Legislature recognized the merit of this proposal, and in 1935 the following act (chapter 421, Acts of 1935) was passed authorizing the construction of a hospital to be known as the Norfolk State Hospital. It was clearly the intent of the Legislature that the institution be built within a comparatively brief time. The next and final step, that of appropriating the money, will make the hospital a reality. This step should be taken at once.

CHAPTER 421, ACTS OF 1935.

AN ACT PROVIDING FOR THE ESTABLISHMENT OF THE NORFOLK STATE HOSPITAL FOR THE CARE OF THE CRIMINAL INSANE.

Be it enacted, etc., as follows:

SECTION 1. As soon as funds become available for the construction of a state hospital for the criminal insane, the commissioner of correction is hereby authorized, with the approval of the governor and council, to transfer to the department of mental diseases the control of so much of the land now occupied by the state prison colony at Norfolk, as, in the opinion of the commissioner of correction, the commissioner of mental diseases and the chairman of the commission on administration and finance, may be necessary for such a state hospital.

SECTION 2. Upon the transfer to the department of mental diseases of the control of any land under section one there shall be constructed thereon a state hospital for the criminal insane, to be known as the Norfolk state hospital, and any funds received from the federal government may be used for such construction. Upon receipt of notification from said department that said state hospital is ready for the reception of patients, the governor shall issue his proclamation establishing said hospital and fixing a time for the opening thereof for use as a state hospital for the criminal insane. Thereupon said hospital shall be subject to all provisions of law applicable to state hospitals for the criminal insane, under the control of said department. As soon as may be after the time fixed by such proclamation,

all insane criminals then confined at the Bridgewater state hospital shall be transferred to said Norfolk state hospital or to some other state hospital under the control of said department.

SECTION 3. Section five of chapter nineteen of the General Laws, as amended by section two of chapter three hundred and fourteen of the acts of the current year, is hereby further amended by inserting after the word "hospital" the first time it occurs in the eighth line the words: — , Norfolk state hospital, — so as to read as follows: — *Section 5.* The boards of trustees of the following public institutions shall serve in the department, Belchertown state school, Boston psychopathic hospital, Boston state hospital, Danvers state hospital, Foxborough state hospital, Gardner state hospital, Grafton state hospital, Walter E. Fernald state school, Medfield state hospital, Metropolitan state hospital, Monson state hospital, Norfolk state hospital, Northampton state hospital, Taunton state hospital, Westborough state hospital, Worcester state hospital and Wrentham state school.

SECTION 4. Section twenty-five of chapter one hundred and twenty-three of the General Laws, as amended by section three of said chapter three hundred and fourteen, is hereby further amended by inserting after the word "hospital" in the tenth line the words: — , Norfolk state hospital, — so as to read as follows: — *Section 25.* The state institutions under the control of the department shall be Worcester state hospital, Taunton state hospital, Northampton state hospital, Danvers state hospital, Grafton state hospital, Westborough state hospital, Foxborough state hospital, Medfield state hospital, Monson state hospital, Gardner state hospital, Wrentham state school, Boston state hospital, Walter E. Fernald state school, Boston psychopathic hospital, Belchertown state school, Metropolitan state hospital, Norfolk state hospital, and such others as may hereafter be added by authority of law.

SECTION 5. Of the appointments of trustees of the Norfolk state hospital which shall be originally made by the governor, with the advice and consent of the council, under authority of this act, as soon as may be after the proclamation of the governor provided for in section two, one shall serve until the expiration of one year, one until the expiration of two years, one until the expiration of three years, one until the expiration of four years, one until the expiration of five years, one until the expiration of six years, and one until the expiration of seven years, from the first Wednesday in February following such proclamation, subject, however, to the provisions of section six of chapter nineteen of the General Laws.

SECTION 6. Section three shall become effective upon the original appointment of the trustees of the Norfolk state hospital, and section four upon the proclamation provided for in section two.

Approved July 15, 1935.

The following table outlines the factor of overcrowding at the Bridgewater State Hospital for the Criminal Insane for 1923 to 1938, inclusive:

Bridgewater State Hospital for the Criminal Insane — Admissions during Years ending September 30, 1923 to 1938.

YEARS.	Rated Capacity.	Patients in Institutions.	Over-crowding (Per Cent).	ALL ADMISSIONS. ¹	
				First Admissions.	Readmissions.
1923	908	876	-3.52 ²	65	14
1924	908	916	.88	68	22
1925	908	915	.77	67	14
1926	908	942	3.74	63	27
1927 ³	908	954	5.06	57	5
1928	908	940	3.52	37	23
1929	908	937	3.19	48	19
1930	908	942	3.74	65	23
1931	908	938	3.30	58	19
1932	908	944	3.96	58	16
1933	908	938	3.30	58	17
1934	908	911	.33	59	3
1935	908	903	-.55 ²	51	10
1936	908	877	-3.41 ²	40	6
1937	908	887	-2.31 ²	40	28
1938	908	895	-1.43 ²	61	43

¹ Transfers excluded.

² Indicates under capacity.

³ Court admissions only for the years 1923 to 1927.

The rated capacity of this institution has remained at 908 beds during the entire period. Bridgewater was under capacity 3.5 per cent in 1923. Beginning with 1924 onward we see the number of patients rising gradually above the rated capacity. The greatest degree of overcrowding, 5.0 per cent, occurred in 1927, when 954 patients were cared for in a rated capacity of 908 beds. From 1928 to 1933 overcrowding at Bridgewater remained on an even level of 3.3 per cent; 1934 saw a drop in overcrowding to .3 per cent; 1935, 1936, 1937 and 1938 show a condition of under capacity. In 1938 there were 1.43 per cent fewer patients than beds in accordance with the rated capacity.

The first and readmissions are outlined in the last two columns of the table. We note that the largest number of admissions occurred in the years 1924 to 1926, when 90 persons were committed to Bridgewater. Following 1926 the admissions were on a somewhat lower level for three years, returning to a total of 88 in 1930; 1931 to 1933 are slightly lower. From 1934 on we see a decidedly lower level of admissions, there being a total of 62 persons coming to Bridgewater in 1934, 61 in 1935, 46 in 1936, and 68 in 1937, but a rise to 104 in 1938. From these figures it is evident that the number of criminal insane committed to the Bridgewater State Hospital has shown a tendency to decrease over the past fifteen years. The rise in 1938 evidently comprised a number of short residence cases, as the number of patients remaining in hospital at the end of the year does not show any substantial increase.

APPENDIX 5.

PROBLEM OF THE MENTAL DIVISION AT THE TEWKSBURY STATE INFIRMARY.

In the mental department of the Tewksbury State Infirmary, an institution in the State Department of Public Welfare, are nearly 500 patients suffering from chronic mental disease. Most of them will have to be taken care of for life, and the problem is mainly a custodial one.

The superintendent, Dr. Laurence K. Kelley, has suggested either that these patients be removed from the Infirmary, or that he be given authority to receive new patients from the community and conduct a psychiatric service for them in order to stimulate the practice of psychiatry at the institution.

On September 1, 1931, the Infirmary stopped accepting patients from state mental hospitals. As of September 5, that year, there were 784 patients in the mental department. The gradual reduction in the number of patients is shown in the table on page 99.

The table reports the changes in overcrowding at the Tewksbury State Infirmary for the years 1923-38, inclusive. The overcrowding at Tewksbury reached its high point in 1930, when 807 patients were cared for in a rated capacity of 673 beds. Following 1930, overcrowding dropped rapidly, becoming an under-capacity condition in 1934, when 577 patients were cared for by a rated bed capacity of 603. This year this institution was 4.3 per cent under capacity. In succeeding years the bed capacity remains the same, but the number of patients dropped to 543, 512, 484 in 1935, 1936 and 1937, respectively. The year 1937 shows the condition of under capacity to the extent of 19.7 per cent.

The sudden reversal of overcrowding at Tewksbury is explained by the decreasing number of admissions as observed in the last two columns of the table. While this institution had been admitting about 40 to 50 patients per year, in 1932 the admissions dropped to 3. From 1933 on there have been no

admissions to this institution. Certain patients are discharged or die each year, and, with no admissions to replace them, we may expect the gradual disappearance of mental patients at the Tewksbury State Infirmary.

Mental Wards, Tewksbury State Infirmary — Admissions during Year, Rated Capacity, Patients within Hospital and Overcrowding and Under Capacity on September 30 of Each Year, 1923 to 1938.

YEARS.	Rated Capacity.	Patients in Institutions.	Over-crowding (Per Cent).	ALL ADMISSIONS. ¹	
				First Admissions.	Readmissions.
1923	673	712	5.79	33	4
1924	673	754	12.03	36	3
1925	673	737	9.50	41	4
1926	673	741	10.10	46	1
1927 ²	673	773	14.85	40	3
1928	673	788	17.08	47	4
1929	673	788	17.08	53	2
1930	673	807	19.91	48	2
1931	673	694	3.12	33	9
1932	603	657	8.95	2	1
1933	603	605	.33	-	-
1934	603	577	-4.31 ³	-	-
1935	603	543	-9.95 ³	-	-
1936	603	512	-15.09 ³	-	-
1937	603	484	-19.73 ³	-	-
1938	603	469	-22.22 ³	-	-

¹ Transfers excluded.

² Court admissions only for the years 1923 to 1927.

³ Indicates under capacity.

While the Commission strongly favors the stimulation of the practice of psychiatry, not only in state institutions but among the medical profession at large, to authorize the Infirmary to conduct a psychiatric service would be counter to one of the fundamental recommendations of the Commission.

In our bill to reorganize the Department of Mental Diseases into the Department of Mental Health, we emphasized that the Commissioner should have full powers and responsibility to conduct the Department, and, through the superintendent, the hospitals.

To permit the Infirmary to maintain a psychiatric service would lessen, not strengthen, the control of the Commissioner, as the Infirmary is part of the State Department of Public Welfare, and its officers are responsible to officials in no way connected with the Department of Mental Health.

We therefore recommend that no action be taken at this time in connection with the mental department at Tewksbury State Infirmary, but suggest that in the future the Department of Mental Health, if such a program is feasible, remove a certain number of patients from the Infirmary to its own hospitals, so that within a limited period the Infirmary will be solely concerned with welfare patients.

APPENDIX 6.

PROBLEM OF THE MENTALLY DEFICIENT.

1. INSTITUTIONAL PROVISION FOR MENTAL DEFECTIVES IN MASSACHUSETTS.

(a) *Introduction.*

Before reaching a decision as to the ideal institutional provision for mental defectives in Massachusetts, let us view the subject from its broader aspects. It is known that mental deficiency is a widespread condition affecting all social and economic levels and involving from 2 to 3 per cent of the general population. Thus, there are between 85,000 and 128,000 of such persons in our Commonwealth. Out of these large numbers we have only about 5,200 in the state schools and another 3,200 on the urgent waiting lists. Here we have a total of 8,400 who have failed in the community. This is about 10 per cent of the lowest estimate for this group in the population (85,000). Here is a point rarely discussed in connection with the problem of mental deficiency. We see the remarkable potentialities for good in this group, in that 90 per cent of these handicapped individuals have succeeded in adjusting themselves in the community. However, the main concern, for the present, is with this 10 per cent who are not making the grade.

Mental defectives in the community are subjected to the same social and economic influences which affect all of us. In times of stress the individual who lacks the characteristics making for success feels the pinch first. Consequently, children and adults, able to stay in the community under favorable circumstances, are no longer able to do so, and make application to a state school. This is a situation which has been prominent for the past fifteen or twenty years in this Commonwealth. Changing social valuations in the post-war period, the stepping up of competition, and the continued urbanization of our population have made it increasingly difficult for the mental defective to adjust himself. The world familiar to him has been changing

so rapidly that he has been unable to meet the shifting requirements for social and economic adjustment.

Two pioneers in mental deficiency, Drs. Walter E. Fernald and George I. Wallace, insisted that the state schools should be maintained as training schools and not simply as custodial institutions. During their lives they tried hard to hold to these traditions. However, the demand for admission to the state schools increased to such an extent during the past fifteen years that their successors have been forced to recede from this original position. Circumstances made it impossible to continue to select the same proportions of the higher grade cases — the morons — for training. The idiots, the low grade imbeciles, the mongols, the cretins, the hydrocephalics, the cases of spastic paralysis, and other pathological types, had to be given precedence in the matter of admission. It can be understood that there was very little space left for the higher grade cases, — those making up the trainable moron group. Now it happens that these lower grade cases often become permanent residents of the schools, remaining until their death. Consequently, the schools gradually have become loaded with chronic cases with little chance of discharge. The ideal, of course, is to return to the community each year a number of trained mental defectives which approximates the number of admissions. Thus the annual turnover will permit the admission of new cases.

If the most satisfactory results from the program for the care of mental defectives are to be obtained, the first thing is to return to the emphasis of the ideal of the training principle. Allowing the state schools to become mere custodial institutions for chronic cases is a serious error. By failing to meet, first, obligations to the higher grade mental defectives, we are not only doing them a great injustice, but by such a policy the State is simply postponing inevitable expenditure. The trained mental defectives are a good bet for community adjustment. The idle and untrained mental defective drifts straight into trouble.

Not all high grade mental defectives need the state school. However, certain ones emerge from the mass comparatively early, and show by their conduct that thorough institutional training will be necessary. When adequate training is not available they become serious problems. Massachusetts has always been noted for its educational opportunities. Yet the group needing education and training most, those carrying the

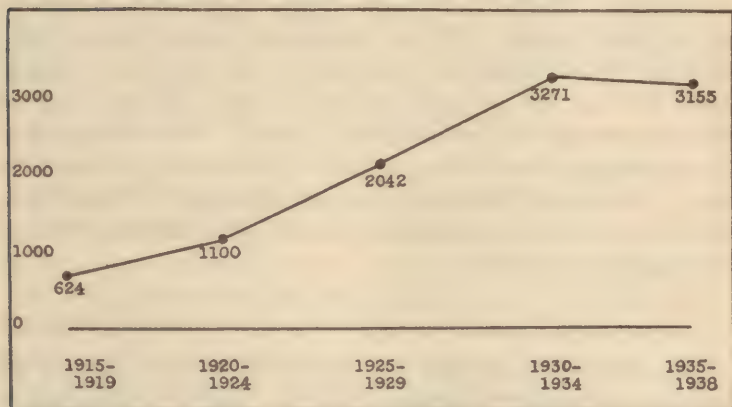
highest potentialities for disaster, is being denied such training. The humanitarian principle behind the thought is only half of the matter. Such a program would be the best form of insurance for society against possible future difficulties with this particular group.

Let us review the experience of the past thirty years in reference to the institutional provision for the mentally defective in Massachusetts, and see if it offers any suggestions for changes in our present program.

(b) *The Increasing Waiting Lists, 1915-38.*

Massachusetts opened its first state school for mental defectives in South Boston in 1848. Over the succeeding years a slow but steady increase in the demand for institutional provision was made up to about 1900. From that date to 1915 the demand increased slightly and was answered by the opening of a second state school in 1907 (Wrentham). Over the

GRAPH 1
NUMBERS ON THE WAITING LISTS OF THREE STATE SCHOOLS,
1915-1938: AVERAGE NUMBERS FOR PERIODS



twenty-four year period, 1915-38, there has been an unprecedented increase in the demand for admission to the state schools maintained by the Commonwealth. As the two schools could fulfill only part of the demands made upon them, it became necessary to establish a "waiting list" on which the names and histories of persons seeking admission were recorded. The numbers on these lists represent the excess remaining after

the schools have admitted all cases possible. Graph 1, on page 103, pictures the tremendous increase in demand over the period mentioned.

During the five-year period, 1915-19, there was an average of 624 cases on the waiting lists of the two state schools (Waverley and Wrentham). In 1922 a third school was opened, but in spite of this increased provision the period 1920-24 saw a yearly average waiting list of 1,100 persons. During 1925-29 this number doubled, rising to 2,042. In 1930-34 it rose another thousand cases to an average of 3,271, and in 1935-38 dropped to 3,155. This slight drop in the waiting lists was occasioned by the fact that state schools were able to eliminate certain old cases from their waiting lists. In the effort to keep the waiting lists within reasonable proportions, the schools were requested to go over their lists carefully and eliminate the names of all patients who could not be considered as active applicants. The reviewing of these cases resulted in the reductions noted. From 624 to 3,271 there is a fivefold increase. Evidently something epochal had happened to the social fabric of Massachusetts in the post-war period which made it less possible for the mental defectives to adjust themselves in the community; that is, to the same degree that had been possible in the earlier years. A 50 per cent rise in waiting lists in 1930-34 over 1925-29 could be attributed to the well-known depression, but the 100 per cent increase of 1925-29 over 1920-24 occurred during the post-war boom period. While this particular period may have been a good one economically, it is evident that it introduced factors, such as a stepping up of competition, which emphasized the intellectual and social shortcomings of the mentally deficient.

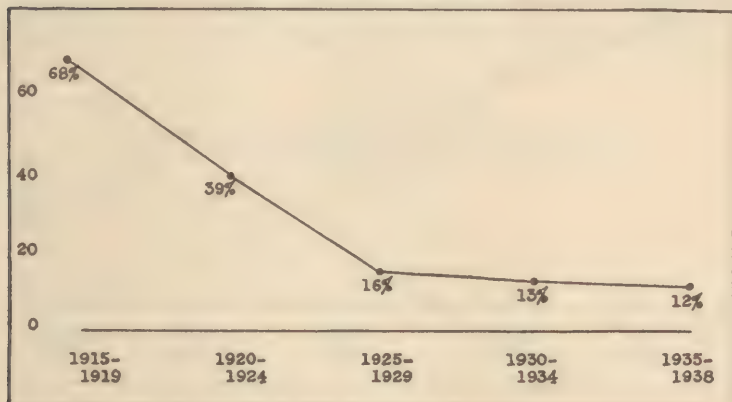
(c) *Decreasing Proportions of Waiting Lists Admitted, 1915-38.*

This trend affected the administration of state schools for the care of mentally defective children. The first effect was to make more difficult the selection of cases for admission. Graph 2, following, shows how smaller and smaller proportions of the waiting lists could be admitted as time went on.

In 1915-19 the schools could admit 68 out of every hundred on their waiting list. They could select a certain proportion of the low grade cases, the pathological types, the imbeciles and still have room for a certain number of the higher grade cases showing potentialities for training and possible parole.

In 1920-24 they could admit but 39 out of every hundred cases on the waiting list. Here the choice was becoming more circumscribed. In 1925-29 the percentage of the waiting list

GRAPH 2
PERCENTAGE OF TOTAL CASES ON THE WAITING LISTS WHICH
WERE ADMITTED 1915-1938



that could be admitted dropped to 16 per cent; in 1930-34, to 13 per cent; and in 1935-38, to 12 per cent. In these last two periods the schools could admit but 13 and 12 out of each 100 awaiting admission to their institutions.

(d) *Decreasing Intelligence of Admissions, 1915-38.*

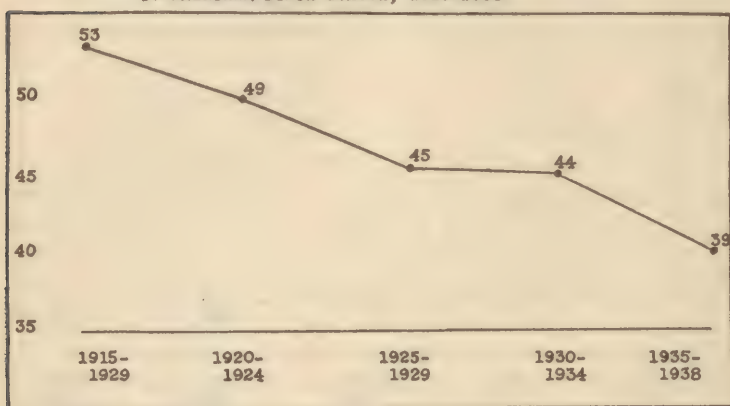
In this situation it is evident that the schools were being limited in their selection to the most urgent cases, — those of lower mental grade and the pathological types. This necessary selection of cases from the lower intellectual levels is shown by Graph 3, following, which gives the average intelligence quotients of admissions to the Wrentham State School over the period 1915-38. These data were available for Wrentham only, but show the trends quite unmistakably.

With the small waiting list in 1915-19, which permitted 68 per cent of cases on the waiting list to be admitted, we find an average admission intelligence quotient of .53. For this period all of the admissions averaged in the moron group. The remarkable possibilities of training and discharging individuals in this high grade group are evident. In the four following five-

year periods the average intelligence quotients of admissions dropped to .49, .45, .44 and .39. In these four periods the averages had dropped from the moron to the imbecile group.

GRAPH 3

AVERAGE INTELLIGENCE QUOTIENT OF PATIENTS ADMITTED
TO WRENTHAM STATE SCHOOL, 1915-1938.



It is noted that the limitations of selection have produced a marked lowering of the intellectual status of admissions coming to the state schools.

(e) *Decreasing Discharge Rates, 1915-38.*

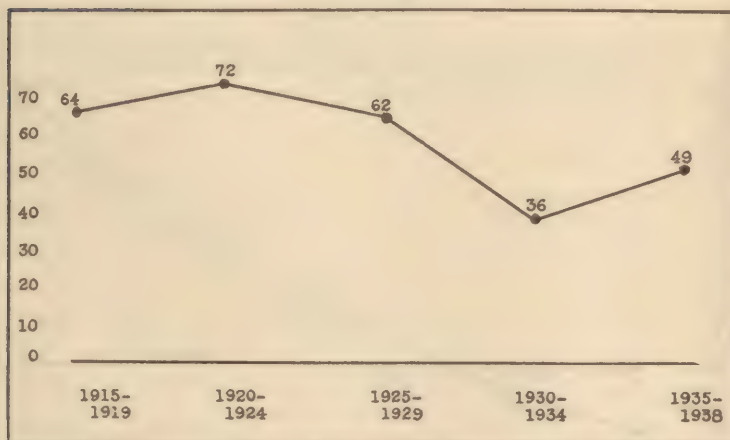
The effect of this elimination from the admissions of the major portion of the higher grade cases, the morons, were as might be expected. The less promising cases being admitted tended to accumulate within institutions. With few of the higher grade cases available to preserve the annual turnover, it is found that the discharge rates were seriously interfered with. Graph 4, following, pictures the discharge rates for the five periods under discussion.

For the first five-year period, 1915-19, the discharge rate was 64 per 1,000 under care. In 1920-24 it rose slightly to 71, dropped to 62 in 1925-29, decreased about 50 per cent to a rate of 36 in 1930-34, and rose in 1935-38 to 49. A certain part of the low discharge rate of 1930-34 is due to the depression period. However, this is not responsible for all of this drop. Even during the depression we were still able to place trained mental defectives on parole, even though the wages were somewhat lower than those of previous periods. The fact

that people could not pay the usual high salaries for domestic or farm help made them search for help that would accept a lower salary. Our state school social service departments reported that they had little difficulty in placing boys and girls, even though they had to accept somewhat lower salaries. In connection with the foregoing it should be recalled that the average school stay of cases discharged is between five and six years. Consequently there is a decided lag in the effect produced by the lower grade admissions. Admissions of 1915,

GRAPH 4

PATIENTS DISCHARGED FROM STATE SCHOOLS, 1915-1938:
RATES PER 1,000 UNDER TREATMENT



for example, were not discharged until about 1920 or 1921. The high discharge rates of 1925-29 were due, in part, to the comparatively high I. Q. of admissions of the period 1920-24.

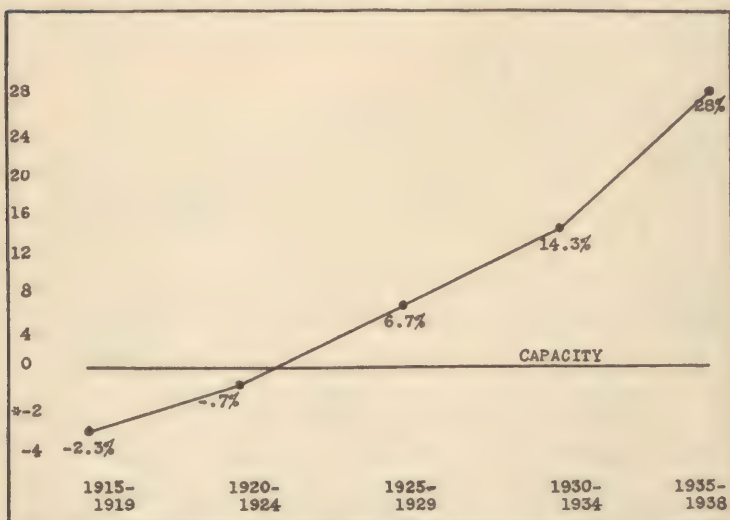
Here there is concrete evidence of what happens when the training school ideal is necessarily forgotten in the press of circumstances and supplanted by the principle of custodial care. It may be observed that during the last two periods the discharge rates were lowered materially. With fewer individuals leaving the state schools one can see that the inevitable accumulation of more or less permanent residents is already an established fact.

(f) *Increasing Overcrowding, 1915-38.*

Now what happens when the pressure for admission continues and the discharge rates fall to low levels? The state

schools are faced with waiting lists of thousands of urgent applicants, and, at the same time, a decreasing turnover of patients to provide vacant beds. It is quite understandable that they would make some effort to meet the many demands for admission. What happens under these circumstances? Graph 5, following, pictures the overcrowding in state schools for the years 1915-38. These figures are based on a comparison between actual capacities and the number of patients within institutions for each period.

GRAPH 5
OVERCROWDING IN STATE SCHOOLS, 1915-1938: PERCENTAGES



*Minus (-) means "under capacity"

During the two periods 1915-19 and 1920-24, which show little pressure of admissions and high discharge rates, the overcrowding remained at low levels. In the later years the numbers seeking admission increased enormously (as may be noted in Graph 1). In the face of this clamor the schools felt obliged to keep the number of admissions up to the numbers admitted during previous years, at least. Had it been possible to continue discharging the same numbers each year, a certain number of vacancies would have been available. However, when the lower grade admissions could not be discharged the overcrowding mounted accordingly. During the years 1915-25

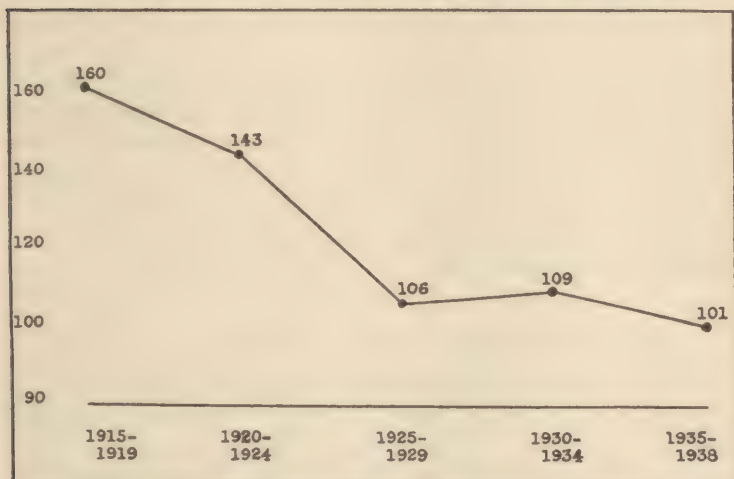
the state schools were actually under capacity. In 1925-29 the overcrowding was 6 per cent, in 1930-34 it rose to 14 per cent, and in 1935-38 to the high of 28 per cent.

(g) *Decreasing Admission Rates, 1915-38.*

How has all of this affected the number of cases coming into the state schools? In the face of overcrowding it is obvious that the schools must curtail admissions, or, at least, not increase admissions. Yet they are between two fires. On the one hand they face a mounting overcrowding, and, on the other,

GRAPH 6

NUMBER OF ADMISSIONS COMPARED WITH BED CAPACITY OF STATE SCHOOLS,
1915-1938: ADMISSION RATES PER 1,000 BEDS OF CAPACITY



more insistent demands for admission from their increasing waiting lists. However, the physical impossibility of caring for larger numbers in the limited space available has finally won out, and we see the admission rates decreasing. The figures are available in Graph 6, above.

Comparing the numbers of admissions with the available capacity one sees how the admission rates struck a high point in 1915-19. In that period 160 children were admitted per 1,000 beds of capacity. This period showed a small waiting list, the highest average I. Q., a high discharge rate, and no overcrowding within state schools. The periods 1925-29,

1930-34 and 1935-38 show lower admission rates, with reductions to 106, 109 and 101 admissions per 1,000 beds of capacity. These periods showed tremendous waiting lists, with low average intelligence of admissions, low discharge rates and high percentages of overcrowding.

We are back at the beginning of the vicious circle. Now the schools must begin all over again and be even *more* careful to select only the most urgent cases, — those of the pathological types and those of lower mental gradings. Again we are to go through the sequence of increasing waiting lists, admission of low grade cases, decreasing discharge rates and increasing overcrowding. Allowing circumstances to turn the State away from the ideal of a training program to the dubious goal of permanent custodial care has meant more serious difficulties.

As a part of a long-range program of decreasing admission rates and minimizing future construction programs, the Department, in 1938, inaugurated the system of boarding in private homes certain carefully selected mentally defective patients. The number of cases tried to date is small, the trial period has been only five months, but the effects have been sufficiently encouraging to warrant extension of the program. A similar program is being tried in New York State, and has been used in the hospitals for the adult insane in this Commonwealth for many years.

(h) *State School Provision in Other States, 1933.*

Lest it be thought that Massachusetts has been too backward in this matter of institutional provision for its mental defectives, a table is being presented which shows the efforts made by Massachusetts and other leading States in this direction as of the year 1933. In 1929 Massachusetts was second in provision for mental defectives in the United States. In 1933 she had dropped to fifth position (Department of Census figures for United States for 1933). Table 1 shows the neighboring State of New York with a slightly lower residence rate than Massachusetts. It should be explained, however, that New York has made remarkable strides since 1933 in the direction of adding to the bed capacity within state schools; for example, in 1935 New York had *eleven* new buildings under construction at Letchworth Village, and other new constructions in process at *four other state schools*. Over the same years Massachusetts had made little progress.

TABLE 1. — *Patients within State Schools for Mental Defectives in the Ten Leading States, 1933.*

[Rates per 100,000 population, 1930 census.]

STATE.	Population, 1930 Census.	Mental Defectives within State Schools.	Rate per 100,000 Population.
Delaware	238,380	317	132.98
Wyoming	225,565	285	126.34
Iowa	2,470,939	2,899	117.32
New Hampshire	465,293	543	116.70
Massachusetts	4,249,614	4,771	112.26
Idaho	445,032	493	110.77
North Dakota	680,845	730	107.21
Maine	797,423	796	99.82
New York	12,588,066	12,359	98.18
District of Columbia	486,869	465	95.50

NOTE. — In 1929 a similar study showed New Hampshire in first position and Massachusetts second. In five years Massachusetts has dropped from second to fifth position.

(i) Summary.

The Commonwealth had a consistent plan for the development of the institutional care of mental defectives from 1848. This program proved satisfactory until about 1920. The post-war period, for some unknown reason, was very rough on mental defectives in the community, with the result that thousands began to clamor for admission where hundreds had come before. The Commonwealth faced a new condition here, and one which demanded extraordinary provisions. A new school was opened in 1922, but this was not sufficient to cover the increasing needs. Dr. George M. Kline, then the Commissioner, believed that another school was necessary, and in 1930 requested the sum of \$50,000 for the purchase of land for a fourth state school. An additional \$75,000 for plans, etc., was appropriated in 1931. However, the depression economy was with us at about that time, and it checked the development of this fourth school before it could get started.

Now we find that the Commonwealth is definitely behind schedule in its institutional provision for the mentally defective. It is obvious that steps must be taken soon to remedy this situation. While attempts have been made to meet

the vastly increasing demands for institutional provision for the mentally defective, these efforts were far below the requirements of the period under discussion.

At the present time there are about 5,200 persons within our three state schools. These schools are about 31 per cent overcrowded (1938), the actual capacity being about 4,000 beds. This makes the State 1,200 beds short of fulfilling present needs, but by refiguring capacities adjusted for children, this might be cut down to 664 beds. In addition, there are over 3,200 cases on the combined waiting lists of the three state schools. This list is kept current, the books being balanced each month. New additions to the waiting list are added, and withdrawals are subtracted so that the Department has an up-to-date figure on its waiting lists for the first of each month. This work has been carried on by the Statistical Division for the past eight years. Six hundred and sixty-four beds are needed to relieve the present overcrowded condition, plus 3,200 beds for those on the present waiting lists, or a total of 3,864 new beds required. This means practically doubling the present capacity of 4,000 beds, raising it to a new total of 7,864 beds. Bringing each of the present schools up to 2,000 beds each would raise the total capacity from 4,000 to 6,000 beds and take care of the existing overcrowding (600 beds) and remove 1,400 cases from the waiting list. The question of providing a fourth state school for the 1,800 cases remaining on the waiting list should receive more study.

However, with a bed capacity of 7,864 beds the Commonwealth would be able to bring institutional care of the mental defectives to its previous high levels; to pursue a satisfactory training program; to return a certain proportion of the moron group to the community; and to actually save the State money through an active prevention of costly failures on the part of untrained mental defectives. The hope of psychiatry is in prevention. Giving mental defectives a means of meeting life's problems is prevention at a high level.

(j) *Recommendations.*

1. Increase the capacity of the present state schools to approximately 2,000 beds each. A new school has been given some study, but from the sole viewpoint of economy this is temporarily postponable. The first step should be to increase the capacity of the present schools as noted above. The next

step would consist of increasing the size of Templeton Colony by adding low construction cost buildings for able-bodied patients chronologically beyond the school-training age. Such patients would be transferred from the high-cost schools to Templeton, permitting admission to the schools of the younger, trainable groups on the waiting lists.

2. Each state school should have a sum added to its annual appropriation for the purpose of providing funds for the boarding out, in the community, of selected cases now in residence within schools. This would enable certain mental defectives, past the training period, but not suitable for parole, to be placed in selected homes in the community, at an estimated cost of \$4 or \$5 per week. This cost is far less than the state school maintenance costs, which, in 1938, averaged \$7.75 per week.

3. It would be advantageous if statutory provision were made whereby transfers from the schools to the Department were made possible, and in Appendix 10 we have recommended legislation to authorize such transfers.

2. COMMUNITY CARE OF THE MENTALLY DEFECTIVE.

(a) *Introduction.*

In addition to those mental defectives needing institutional care there are numerous cases which can be cared for in the community if given proper supervision. The mental defective presenting a behavior problem in addition to his mental deficiency needs the twenty-four hour supervision and training of the state school. However, other thousands of mental defectives do not show these deviations in behavior. They simply lack initiative and the judgment necessary to control themselves and their affairs successfully. With a little assistance they get along remarkably well in the community.

(b) *Community Supervision as Carried on by the Division of Mental Deficiency.*

When the Division of Mental Deficiency was created in 1922, Dr. Walter E. Fernald advised the Commissioner, Dr. Kline, that, in addition to the maintenance of the central registry and supervision of school clinics, the Division should make plans for carrying out a program of community supervision of mental defectives. Beginning with two social workers

the Division exercised supervision over cases referred or committed to it, with the thought of keeping these mentally defective persons in the community and rendering unnecessary their admission to one of our state schools. Various social agencies and other state agencies have referred cases to the Division for action.

After acceptance, the social workers find positions for these persons, keeping in constant touch with employers and the homes involved. If one position or wage home proves unsatisfactory, another is provided. Advice is given to many parents of the younger children, and active supervision is exercised over those in the older ages or from sixteen years up. During the fifteen years the Division has been operating, several hundred mental defectives have been assisted to an adjustment in the community, and thus admission to a state school rendered unnecessary.

Some of the research work in mental deficiency in reference to state school discharges has shown that the average case coming into a state school costs the Commonwealth between \$2,000 and \$2,600 before his discharge or death. If the Division has succeeded in keeping only 500 cases out of institutions, the Commonwealth has saved an expenditure of over a million dollars. The cost of the three social workers over this fifteen-year period has amounted to about \$67,500 in salary. Basing the comparisons on this minimum number of 500 cases, we see that community supervision has amounted to only about 6 per cent of the cost of state school care.

(c) *Present Need for Community Supervision.*

Now one might ask, what are the needs for community supervision throughout the State? To answer this it will be necessary to review present knowledge of the extent of mental deficiency throughout our population. When the Division of Mental Deficiency was started, in 1922, a part of the planned work was the maintenance of a central registry for mental defectives. Dr. Fernald expressed the opinion that the State must first learn of the extent of the problem of mental deficiency before it could intelligently plan a program. The first cases reported to the central registry came from the fifteen traveling school clinics. Over the later years, however, this has been organized a little more extensively, and now the Division receives monthly reports from all institutions, giving

names and descriptive data on new cases of mental deficiency contacted during the month. These sources are as follows: (1) traveling school clinics; (2) admissions to state hospitals; (3) admissions to state schools; (4) cases placed on the waiting lists of state schools; (5) defective delinquents examined by hospital and Department psychiatrists; (6) out-patient examinations of state hospitals; (7) out-patient examinations of state schools; (8) mental hygiene clinics; (9) habit clinics; (10) child guidance clinics; (11) adjustment clinics; (12) defective delinquents admitted to Bridgewater; (13) mentally defective prisoners examined under section 100A, chapter 123; (14) cases referred to the Division of Mental Deficiency; (15) cases examined by the Division of Mental Hygiene; and (16) children examined by the psychological clinic of the Springfield schools. During last year, for example, there were 2,313 new cases of mental deficiency reported through the school clinics and an additional 2,744 from other sources. Here is a total of 5,057 *new cases of mental deficiency* being reported to the Department each year. Out of these 5,057 only about 400 are admitted to our state schools. It is apparent that there are about 4,600 mental defectives coming to the attention of the Department each year, who are remaining in the community. It is estimated that there are now a total of over 60,000 cases so registered. These figures give some idea of the extent of the problem in Massachusetts.

Many of these children are being cared for by the educational system through special classes, and other thousands are being cared for at home. Many will never need to come to a state school, and others will adjust in the community without supervision. However, in this number of over 5,000 coming to the attention of the Department each year there are many whose general behavior and conduct is such that they will require state school care later if not given a helping hand in the younger years. It has been the experience of the Department that mentally retarded children do very well as long as they are under the supervision of the special classes in the public schools. When these children leave the schools, however, and there is no definite plan for keeping them busy, their troubles begin. Without training for any particular kind of work they drift into the easiest thing at hand. They are frequently made use of by persons not unwilling to take advantage of their intellectual shortcomings. There is a distinct need for the supervision of all children leaving special classes.

For two or three years these children need a guiding hand to help them in securing work and to aid them in their general adjustment.

It is not certain, as some extremists allege, that the mental defective is a "menace to civilization." Basically the mental defective wants to do the right thing as much as any one else. However, he lacks the intelligence and judgment to know when questionable propositions are being put up to him. Consequently, he often gets involved in doubtful activities without knowing what it is all about. The mental defective wants to be like other people and to do his part. If he is given half a chance in this direction he will turn out to be a steady, reliable worker and a self-supporting citizen. Without this helping hand his potentialities for difficulties and possible failure are decidedly above the average.

(d) Plan for Enlarging the Present Facilities for Community Supervision.

Present needs require a comprehensive community supervision plan to study every case reported to the central registry or on waiting lists to state schools. Experience with cases under supervision of the Department has shown that remarkable community adjustments are possible with cases that are marked for admission to a state school.

The Commonwealth should consider it vitally important to guide these cases away from the paths that lead to maladjustment and eventually the state school. Concentrating upon state school provision alone has been tried, with the results as outlined in Graph 1. Now it becomes necessary to go back of this state school plan and reach these mental defectives *before* they develop the characteristics which place them on the waiting lists.

In this community supervision the Division of Mental Deficiency has been confined to an advisory capacity for children who are cared for at home by their parents or to the supervision of older cases who are able to earn their own living. There have been many instances in which the Division has wished to place certain cases in boarding homes.

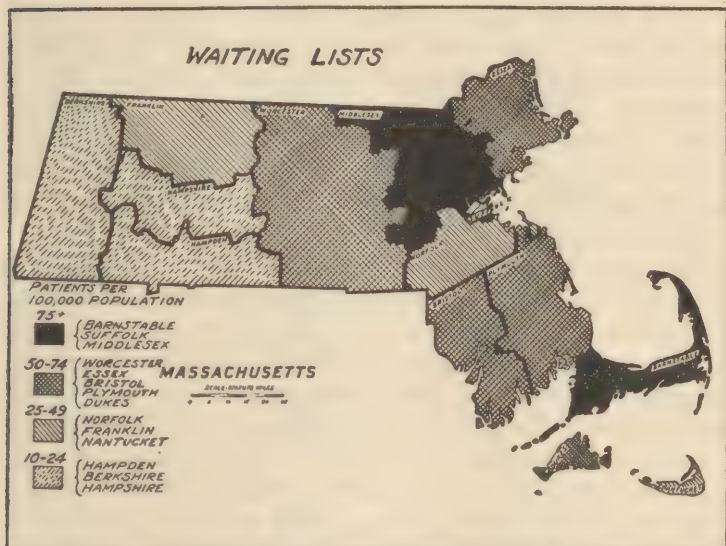
There are many younger children or children with physical infirmities who are without parents or relatives and yet who need understanding home care. If the Division had funds

available, it could arrange for temporary boarding homes at a rate of \$4 or \$5 per week, and thus keep these children in the community.

Ordinarily, cases of this sort are placed on the waiting list and marked as urgent. In reality the financial difficulty is the only factor making the case urgent. Their conduct does not warrant institutional care. They could be cared for in the community if some means were available for paying for their maintenance.

GRAPH 7

RESIDENCE OF APPLICANTS ON WAITING LISTS OF STATE SCHOOLS, NOVEMBER, 1936: RATES PER 100,000 ESTIMATED POPULATION OF SAME COUNTY



For the first time in the history of the Commonwealth, the proposal for boarding out of mental defectives in the Department was inaugurated in 1938, when the Legislature appropriated a sum for this purpose. However, the statutory right of the Department to continue this worthy program was overlooked in the reorganization bill (chapter 486 of the Acts of 1938). The Commission recommends the re-establishment of this power to the Department, and appends suggested legislation to that end (see Appendix 10).

It should be remembered, of course, that this boarding out plan will not eradicate the waiting lists nor necessarily obviate a certain amount of enlargement of the state schools.

Mental defectives fall into many classes in reference to intelligence, personality, conduct, physique, health, etc., much in the same manner as the general population. Mental defectives with certain combinations of characteristics need state school training, and cannot get along in the community satisfactorily without it. There are others, however, who can get along in the community if a good home and understanding care are provided. It is suggested that the State make an effort to take certain suitable children without financial resources out of the schools and put them in the community at a lower cost than that of institutional provision.

As we view the larger problem of mental deficiency throughout the State, it is obvious that other sections as well as Boston need the service now being provided by the Division of Mental Deficiency. Graph 7, on page 117, shows the geographic distribution of cases on the waiting list. Middlesex, Suffolk and Barnstable are high in rates for cases on the waiting lists. The eastern half of the State would need, therefore, larger numbers of supervising social workers.

It is suggested that, when possible, the work of the Division of Mental Deficiency be extended to include different sections of the State. Additional social workers could contact all waiting list cases, problem cases reported to the central registry, behavior problems in special classes, and all children leaving special classes. They could act chiefly in an advisory capacity to parents or relatives in reference to the home care and treatment of children being brought to our attention. Every effort would be made by these social workers to *keep these children in the community* rather than admitting them to a state school. If their characteristics permit it, positions would be obtained for them and boarding homes arranged.

The following table gives the list of cities and towns in Massachusetts and the number of children on the waiting list of our three state schools coming from each of these localities. This geographic distribution of cases gives a suggestion of the number of workers required for the supervision of this group.

TABLE 2. — *Cases on the Waiting List of the Three State Schools on November 30, 1936, by County and City or Town of Residence.*

[Taken from Department's 1937 Report.]

County and City or Town of Residence.	Num-ber.	County and City or Town of Residence.	Num-ber.	County and City or Town of Residence.	Num-ber.
BARNSTABLE . . .	46	Marblehead . . .	4	Concord . . .	4
Barnstable . . .	10	Merrimac . . .	4	Dracut . . .	1
Bourne . . .	2	Methuen . . .	17	Everett . . .	36
Brewster . . .	2	Middleton . . .	1	Frammingham . . .	19
Chatham . . .	1	Nahant . . .	2	Holliston . . .	1
Dennis . . .	7	Newbury . . .	1	Hopkinton . . .	2
Falmouth . . .	10	Newburyport . . .	24	Hudson . . .	13
Mashpee . . .	2	North Andover . . .	1	Lexington . . .	6
Orleans . . .	2	Peabody . . .	15	Lincoln . . .	1
Provincetown . . .	8	Rockport . . .	5	Littleton . . .	3
Yarmouth . . .	2	Rowley . . .	3	Lowell . . .	61
		Salem . . .	33	Malden . . .	44
		Saugus . . .	13	Marlborough . . .	10
BERKSHIRE . . .	18	Swampscott . . .	3	Maynard . . .	7
Adams . . .	4	Topsfield . . .	1	Medford . . .	48
Cheshire . . .	1			Melrose . . .	11
Great Barrington . . .	1	FRANKLIN . . .	20	Natick . . .	12
Lenox . . .	1	Buckland . . .	2	Newton . . .	35
Otis . . .	1	Charlemont . . .	1	North Reading . . .	1
Pittsfield . . .	5	Conway . . .	2	Pepperell . . .	3
Stockbridge . . .	1	Deerfield . . .	1	Reading . . .	12
Washington . . .	1	Gill . . .	1	Sherborn . . .	2
Williamstown . . .	2	Greenfield . . .	2	Somerville . . .	60
Windsor . . .	1	Heath . . .	2	Stoneham . . .	7
		Montague . . .	4	Tewksbury . . .	84
BRISTOL . . .	216	Northfield . . .	2	Townsend . . .	5
Acushnet . . .	1	Orange . . .	2	Wakefield . . .	18
Attleboro . . .	16	Wendell . . .	1	Waltham . . .	26
Berkley . . .	2	HAMPDEN . . .	50	Watertown . . .	23
Dartmouth . . .	4	Agawam . . .	2	Wayland . . .	2
Dighton . . .	1	Chester . . .	1	Westford . . .	4
Easton . . .	4	Chicopee . . .	10	Weston . . .	1
Fairhaven . . .	10	Granville . . .	1	Wilmington . . .	6
Fall River . . .	57	Holyoke . . .	7	Winchester . . .	17
Freetown . . .	1	Ludlow . . .	1	Woburn . . .	21
Mansfield . . .	12	Monson . . .	3		
New Bedford . . .	75	Palmer . . .	1	NANTUCKET . . .	1
North Attleborough . . .	8	Springfield . . .	7	Nantucket . . .	1
Norton . . .	1	Westfield . . .	5		
Rehoboth . . .	3	West Springfield . . .	2	NORFOLK . . .	153
Seekonk . . .	1	HAMPSHIRE . . .	9	Bellingham . . .	2
Somerset . . .	2	Amherst . . .	1	Braintree . . .	4
Taunton . . .	14	Belchertown . . .	1	Brookline . . .	12
Westport . . .	4	Chesterfield . . .	1	Canton . . .	4
		Easthampton . . .	1	Cohasset . . .	2
DUKES . . .	3	Granby . . .	3	Dedham . . .	6
Goenold . . .	1	Northampton . . .	1	Foxborough . . .	3
Oak Bluffs . . .	2	Ware . . .	1	Franklin . . .	4
				Holbrook . . .	1
ESSEX . . .	363	MIDDLESEX . . .	782	Medfield . . .	2
Amesbury . . .	15	Acton . . .	4	Medway . . .	2
Andover . . .	13	Arlington . . .	16	Millis . . .	2
Beverly . . .	10	Ashby . . .	1	Milton . . .	13
Danvers . . .	10	Ashland . . .	1	Needham . . .	6
Essex . . .	1	Ayer . . .	2	Norfolk . . .	2
Georgetown . . .	1	Bedford . . .	1	Norwood . . .	9
Gloucester . . .	18	Belmont . . .	17	Plainfield . . .	1
Groveland . . .	1	Billerica . . .	4	Quincy . . .	35
Hamilton . . .	1	Bloxborough . . .	2	Randolph . . .	5
Haverhill . . .	35	Burlington . . .	2	Sharon . . .	8
Ipswich . . .	6	Cambridge . . .	110	Stoughton . . .	10
Lawrence . . .	55	Carlisle . . .	4	Walpole . . .	5
Lynn . . .	68	Chelmsford . . .	12	Wellesley . . .	3
Lynnfield . . .	1			Westwood . . .	3
Manchester . . .	1			Weymouth . . .	8
				Wrentham . . .	1

TABLE 2. — *Cases on the Waiting List of the Three State Schools on November 30, 1936, by County and City or Town of Residence — Con.*

County and City or Town of Residence.	Num-ber.	County and City or Town of Residence.	Num-ber.	County and City or Town of Residence.	Num-ber.
PLYMOUTH . . .	87	Revere . . .	33	Northbridge . . .	4
Abington . . .	2	Winthrop . . .	17	North Brookfield . . .	1
Bridgewater . . .	16			Oxford . . .	1
Brockton . . .	28	WORCESTER . . .	325	Phillipston . . .	1
Halifax . . .	1	Ashburnham . . .	2	Shrewsbury . . .	2
Hanover . . .	2	Athol . . .	5	Southborough . . .	2
Hanson . . .	1	Auburn . . .	3	Spencer . . .	1
Hingham . . .	5	Blackstone . . .	1	Sterling . . .	3
Hull . . .	1	Bolton . . .	1	Sutton . . .	2
Kingston . . .	2	Boylston . . .	5	Templeton . . .	2
Lakeville . . .	1	Brookfield . . .	1	Upton . . .	3
Middleborough . . .	5	Clinton . . .	4	Uxbridge . . .	1
Norwell . . .	1	Fitchburg . . .	45	Warren . . .	1
Plymouth . . .	5	Gardner . . .	2	Webster . . .	7
Rockland . . .	2	Grafton . . .	3	Westborough . . .	10
Scituate . . .	3	Harvard . . .	4	West Boylston . . .	5
Wareham . . .	6	Holden . . .	1	Winchendon . . .	3
West Bridgewater . . .	1	Hopedale . . .	2	Worcester . . .	157
Whitman . . .	5	Lancaster . . .	1	Non-residents . . .	—
SUFFOLK . . .	930	Leicester . . .	2	Unknown . . .	288
Boston . . .	834	Leominster . . .	20		
Chelsea . . .	46	Milford . . .	12	Grand total . . .	3,291
		Millbury . . .	5		

The Division of Mental Deficiency is not supervising these cases on the waiting list. To do this six social workers would be needed in the Division, such workers to be located as follows: one worker in Worcester to care for the 422 cases on the waiting list in Berkshire, Hampden, Hampshire, Franklin and Worcester counties; two workers to supervise the 1,145 cases on the waiting list of Middlesex and Essex counties, one worker to be located in Cambridge and the other in Lynn or Lawrence; two workers in Boston to supervise the 930 cases on the waiting list for Suffolk County; one worker in Taunton to supervise the 502 cases from Norfolk, Bristol, Plymouth and Barnstable counties. It is understood, of course, that these six workers can only lay the groundwork of this new activity. However, it is felt that, from the beginning, these six workers would pay their own salaries over many times in the prevention of admissions to our state schools.

The work at first would be frankly advisory. The Division would feel its way cautiously until it could determine the lines along which the work should be developed. The big point of this program, of course, would be that of offering advice to families in reference to home training, etc. Adequate home

training and supervision would do much to keep the mental defective in the community. The point would be to save the institutions for the most serious cases, or those in which no family, relative or financial aid is available. This is preventive work of a high order. Here we have the means of prevention of maladjustment in the individual, and, at the same time, the prevention of future expense to the State.

The age of children coming into the state schools or appearing on the waiting lists points out the fact that constructive work with the mental defectives must be started at an early age; for example, the admission ages of cases coming to the three state schools during 1936 show that 9 per cent were under five years of age (Table 3):

TABLE 3. — *Ages of First Admissions to State Schools, 1936.*

[Rates per 100,000 of same ages in Massachusetts population, 1930 census.]

AGE GROUPS.	FIRST ADMISSIONS.		Accumulative Percentages.
	Number.	Percentages.	
Under 5 years	39	9.11	9.11
5-9 years	122	28.50	37.61
10-14 years	138	32.24	69.85
15-19 years	92	21.49	91.34
20-24 years	23	5.37	96.71
25-29 years	7	1.63	98.34
30 years plus	7	1.63	99.97
Total	428	99.97	-

Approximately 28 per cent were placed in the 5 to 9 year group, about 32 per cent in the ages 10 to 14 years, and more than 21 per cent in the ages 15 to 19 years. More than 37 per cent were 9 years or younger, and nearly 70 per cent, 14 years or younger. Here is seen the necessity of attacking the problem of mental deficiency in the younger and formative years. These children are coming into the state schools at such comparatively early ages that constructive community work will have to be done much earlier than has been anticipated. The State should not wait until the ages of 15 to 20 years before doing anything for the mentally defective. Then it is too late.

The waiting lists show a somewhat similar situation (Table 4):

TABLE 4. — *Age at Time of Placement on Waiting List — Cases listed on November 30, 1936.*

AGE GROUPS.	Number.	Percentage Distribution.	Accumulative Percentages.
0-4 years	397	12.66	12.66
5-9 years	853	27.20	39.86
10-14 years	909	28.99	68.85
15-19 years	607	19.36	88.21
20-24 years	183	5.83	94.04
25-29 years	79	2.51	96.55
30-34 years	52	1.65	98.20
35-39 years	22	.70	98.90
40-44 years	17	.54	99.44
45-49 years	7	.22	99.66
50 years plus ,	9	.28	99.94
Unknown	156	—	—
Total	3,291	100.0	—
Average age	12.7	—	—

NOTE. — Averages and percentages computed minus the "unknown."

More than 12 per cent were under 5 years of age when admission was first sought, nearly 40 per cent were 9 years or younger, and more than 68 per cent were 14 years or under. The waiting lists also are made up of a goodly proportion of cases in the younger ages.

The point is clear. Work on mental defect in the community must be done at a very early age if the State hopes to keep these cases out of the state schools. Conduct and behavior patterns are well set by the age of 12 or 15 years. The State should be on the scene *before* lack of parental understanding or home care, lack of occupation or training suited to his mental age, and, in some cases, actual mistreatment, have made the harmless mental defective into a defective delinquent.

(e) *Departmental Research in Mental Deficiency — Need of Increase in Personnel.*

The Division has had an active interest in research and has had one worker devoting full time to this activity. The records

of the school clinic examinations of retarded children in the public schools provide the basic material for this project. Data are recorded on a specially coded card from the school clinic records in the various institutions. This worker spends part of her time within institutions coding this material directly on the card, and the remainder in the preparation of tables and material for publication. Over the past few years many articles have been published contributing to the general knowledge of the subject of mental deficiency. It has been suggested that two additional workers be added to this project. One worker working full time can code about 4,000 records per year. School clinics are reporting at the present time over 8,000 cases each year. The addition of two workers would enable the Department to keep this work caught up, and have one worker devote full time to preparation of tables, statistical analyses, bibliographies, etc. School clinic examinations now total over 114,000, and this material is of such unusual interest that Massachusetts should be publishing several articles each year based on this subject matter.

(f) *Research within State Schools.*

Each one of the state schools has a remarkable opportunity for study of mental defectives under its care. The Wrentham State School is the only school now equipped for research. They have a special research building with equipment and personnel. This has been opened but recently. A research building, equipment and personnel should be made available to both the W. E. Fernald and the Belchertown State Schools. Both of these schools should be given the opportunity of forwarding research work. In this connection a special point should be made of seeing that adequate personnel is added for research activities. The present medical staffs are loaded to capacity with the usual work and cannot be expected to turn out extra work. Investigations that tell us anything new about mental defectives are a step in the direction of prevention and possible eradication of this condition. Money spent in this direction will bear heavy dividends in later years.

(g) *Recommendations.*

1. Initiate a state-wide plan for the community supervision of mental defectives, increasing the present number of social workers in the Division of Mental Deficiency. This group

would lay the groundwork for study and supervision of children on the waiting lists of state schools, individual problem cases met with in special classes, children leaving special classes, and special problems referred to the central registry.

2. The purpose would be to advise parents of younger mental defectives in reference to home care and training; to co-operate with city, town and school officials and social agencies in reference to placement and training of older defectives; and to secure jobs and supervise homes and recreation of the still older defectives. The whole plan would be built around the thought of (1) *keeping the mental defective in the community*, and (2) providing supervision, assistance and industrial guidance to prevent *maladjustment* and future difficulties on the part of this group.

3. Add permissive legislation and funds to the Department for the purpose of boarding out certain mental defectives. This would permit boarding home care for certain younger or physically handicapped mental defectives who could be kept in the community, but who lack parents, relatives or financial support. Inaugurate boarding out care in connection with each of the schools.

4. Increase the research workers in the Division of Mental Deficiency to assist in the analysis and publication of the vast amount of data available through the 114,000 completed school clinic examinations. This tremendous number of examinations of retarded school children offers information not available in any other place in the world. Massachusetts should take advantage of this unparalleled opportunity to learn more about these mental defectives who are remaining in the community.

APPENDIX 7.

PROBLEM OF PSYCHOTIC CHILDREN.

As in any other branch of modern medicine the problem of psychotic children should be studied, first, from the standpoint of diagnosis; second, from the standpoint of prevention; and third, from the standpoint of treatment. Thinking in terms of identification and treatment at the earliest possible moment, the great value of the habit clinics and the child guidance clinics can readily be seen. These clinics have already been tried in the community. Elsewhere in this report, namely, in the section dealing with mentally deficient individuals and that section dealing with mental hygiene, there will be found detailed comments regarding these two types of clinics.

Generally speaking, the habit clinics care for children from two years of age until six years of age, and the child guidance clinics from six to fourteen years of age. Briefly, these clinics are composed of a psychiatrist, a psychologist to provide mental measurement, and a psychiatric social worker to provide the social histories and such environmental factors as have to do with the case at hand, and to assist in carrying on treatments.

The aim of these clinics is to detect mental aberrations in children during their early stages. By correction of these difficulties it is hoped to ultimately decrease the admission of adult psychotics to the mental hospitals; also to eliminate as far as possible psychoses in children.

Some of these children respond readily to treatment and do not require further care. This is prevention of the best sort. Still other children do require continued treatment. At the present time they have only the alternative of going to the usual large public adult mental hospital, or of staying at home under the care of a private physician, which many times is unsatisfactory and expensive, or finally of going to a private hospital, which, too frequently, is beyond the economic resources of the family. Some of these children find their psychosis complicated by mental deficiency, and these children ultimately are committed to the various schools for mental defectives.

The general and humanitarian problems arising out of the intermingling of psychotic children with psychotic adults are obvious. The psychotic children are the losers as a result of such intermingling. Likewise, the effect of intermingling psychotic children who are mentally deficient with similar children who are not psychotic is very disturbing to the school for the mentally deficient, and is not conducive to proper care for either group.

Over a period of years there has been an average of approximately fifty psychotic children under the age of sixteen who have been cared for in the state hospitals for adult psychotics. A breakdown of this figure is found in the following table, which was made up as of September 30, 1937. There has been

Total Cases, aged 0 to 16 Years, on the Books of State Mental Hospitals, Psychotic Epileptics at Monson, and Psychotic Cases at the Three State Schools, on September 30, 1937.

AGE GROUPS.	GRAND TOTAL.			TOTAL STATE HOSPITALS ONLY.			MONSON STATE HOSPITAL (PSYCHOTIC EPILEPTICS ONLY).			THE THREE STATE SCHOOLS (PSYCHOTIC CASES ONLY).		
	M.	F.	T.	M.	F.	T.	M.	F.	T.	M.	F.	T.
16 years	26	17	43	18	13	31	7	3	10	1	1	2
15 years	21	14	35	12	9	21	3	2	5	6	3	9
14 years	4	12	16	1	4	5	1	3	4	2	5	7
13 years	9	12	21	2	7	9	2	3	5	5	2	7
12 years	4	5	9	3	3	6	1	2	3	-	-	-
11 years	5	5	10	1	1	2	1	2	3	3	2	5
10 years	3	2	5	-	2	2	2	-	2	1	-	1
9 years	5	1	6	1	-	1	2	-	2	2	1	3
8 years	1	4	5	-	-	-	-	2	2	1	2	3
7 years	2	-	2	1	-	1	-	-	-	1	-	1
6 years	2	1	3	-	-	-	2	1	3	-	-	-
5 years	-	-	-	-	-	-	-	-	-	-	-	-
4 years	-	-	-	-	-	-	-	-	-	-	-	-
3 years	-	-	-	-	-	-	-	-	-	-	-	-
2 years	-	-	-	-	-	-	-	-	-	-	-	-
1 year	-	-	-	-	-	-	-	-	-	-	-	-
Under 1 year	1	-	1	-	-	-	1	-	1	-	-	-
Total	83	73	156	39	39	78	22	18	40	22	16	38

very little variation from year to year. There are approximately seventy-five children with varying degrees of psychotic manifestations in the schools for the mentally deficient and in the epileptic hospital.

The Commission has taken occasion to study the methods by which psychotic children are cared for in certain sister States, and has visited certain institutions in this regard. We are convinced it is most important to segregate such children from psychotic adults and from the non-psychotic mental deficient. Purely aside from the dangers and improprieties of intermingling, it is reasonable to expect that concentrated medical service on a group of these children in a given unit would be conducive to far better medical treatment and results. Such a program has already been inaugurated in New York and Pennsylvania. Also, aside from the immediate medical care which would result from concentration of these children in a given unit, is the long-range advantage which would be gained by studying these children in groups during their prolonged hospital stay. This would open up a new branch of research to Massachusetts which undoubtedly would show good returns over a period of years.

One must not forget that children continue to be children even when psychotic, and the normal age traits are present. They respond to training better than adults do because their children's habits are not so well established. Training has a larger place in the care of psychotic children than in the care of psychotic adults. Reports from the States where such treatment is now being carried on indicate that the treatment of the psychotic child can be carried on quite successfully, not only in the matter of treatment concerned, but also in the continuation of education. Other States have found it advisable to have a hospital for psychotic children as a separate unit, distinctly separated from any section dealing with psychotic adults or with non-psychotic children.

The Commission feels that the Commonwealth has made a good beginning for providing facilities for the identification of psychotic children in the community. These facilities should be augmented from time to time, as definite needs are demonstrated and finances will permit.

We feel, however, that the frankly psychotic child has not been given the care and treatment it should receive. Cognizance has been taken of this fact by the Department and the

hospitals for several years, as well as by many social and civic organizations, including the Massachusetts Child Council, the Massachusetts Council for Social Agencies, and the Massachusetts Society for Mental Hygiene.

As a means of relieving the problems of psychotic children, we recommend the construction of a modern and complete new unit of approximately 100-bed capacity to be erected in conjunction with and on the grounds of one of the existing state hospitals. The Commission has thought of the grounds of the Metropolitan State Hospital as a logical site. We believe that this proposal is relatively urgent.

APPENDIX 8.

PROBLEMS OF EDUCATION, PREVENTION AND RESEARCH.

A. INTRODUCTION.

The question of just how prevalent mental disorder is in the State of Massachusetts is a very difficult question to answer, as there are available no reliable statistics concerning the non-hospitalized mentally ill. Reliable data, however, are available concerning the hospitalized patients in the State. The following table gives the census of patients in the various hospitals as of January 1, 1939:

	Patients.
State hospitals (12)	20,314
Hospital for epileptics	1,451
Schools for feeble-minded (3)	5,279
Mental wards, Tewksbury	464
Bridgewater State Hospital	888
Veterans' facilities (2)	1,863
Private hospitals and schools	623
Total	30,882

Recently a professor of medicine at Johns Hopkins stated that approximately a third of his patients who consulted him for what they supposed were physical diseases were in reality suffering from neuroses. This estimate, perhaps, may be applied in general to the relative incidence of neuroses in the practice of the average general practitioner. As has been emphasized, however, no more than a guess can be offered as to the true incidence of the so-called neuroses.

It should be noted that the hospitalization of mental patients has been increasing at a greater rate than can be accounted for by the increase in the general population. The average increase of state hospital patients for which the State has had to furnish additional accommodations from 1904 to 1937, inclusive, has been 416 patients per year.

Total Patients within All Public, Private and Governmental Institutions, September 30, 1904-37.

[Rates per 100,000 estimated state population, and annual increase.¹]

YEAR.	TOTAL.			STATE HOSPITALS. ²			STATE SCHOOLS.			GOVERNMENTAL AND PRIVATE INSTITUTIONS.					
	Num-ber.	Annual Increase.	Rate per 100,000.	Num-ber.	Annual Increase.	Rate per 100,000.	Num-ber.	Annual Increase.	Rate per 100,000.	MENTAL DISORDERS. ³			MENTALLY DEFECTIVE.		
										Num-ber.	Annual Increase.	Rate per 100,000.			
1904	10,948	858	361.3	9,666	897	319.0	847	47	28.0	256	-70	8.4	179	-16	5.9
1905	11,536	588	373.9	10,071	405	326.4	1,028	181	33.3	260	4	8.4	177	-2	5.7
1906	11,805	269	375.7	10,237	166	325.8	1,120	92	35.6	277	17	8.8	171	-6	5.4
1907	12,302	497	384.7	10,602	365	331.5	1,228	108	38.4	307	30	9.6	165	-6	5.2
1908	13,277	975	408.0	11,460	858	352.2	1,332	104	40.9	325	18	10.0	160	-5	4.9
1909	13,943	666	421.2	11,994	534	362.3	1,443	111	43.6	339	14	10.2	167	7	5.0
1910	14,646	703	435.1	12,562	568	373.2	1,567	124	46.5	336	-3	10.0	181	14	5.4
1911	15,129	483	443.0	12,972	410	379.9	1,642	75	48.0	341	5	10.0	174	-7	5.1
1912	15,850	721	457.6	13,481	509	389.2	1,845	203	53.3	362	21	10.5	162	-12	4.7
1913	16,312	462	464.5	13,862	381	394.7	1,922	77	54.7	366	4	10.4	162	-	4.6
1914	16,820	508	472.4	14,202	340	398.9	2,194	272	61.6	357	-9	10.0	67	-95	1.9
1915	17,395	575	482.0	14,657	455	406.1	2,309	115	64.0	367	10	10.2	62	-5	1.7
1916	18,069	674	494.0	15,054	397	411.5	2,582	273	70.6	373	6	10.2	60	-2	1.6
1917	18,612	543	502.1	15,434	380	416.4	2,673	91	72.1	446	73	12.0	59	-1	1.6
1918	18,951	339	504.7	15,476	42	412.1	2,763	90	73.6	491	45	13.1	221	162	5.9

1919 .	18,811	-140 ⁴	404.5	15,409	-67	405.1	2,739	-24	72.0	452	-39	11.9	211	-10	5.5
1920 .	19,177	366	497.8	15,686	277	407.2	2,820	81	73.2	453	1	11.8	218	7	5.7
1921 .	20,041	864	514.9	16,428	742	422.1	2,941	121	75.6	485	32	12.5	187	-31	4.8
1922 .	20,271	230	515.6	16,810	382	427.5	2,849	-92	72.5	443	-42	11.3	169	-18	4.3
1923 .	20,916	645	526.6	17,051	241	429.3	3,239	390	81.6	452	9	11.4	174	5	4.4
1924 .	21,940	1,024	547.0	17,515	464	436.6	3,460	221	86.3	787	335	19.6	178	4	4.4
1925 .	22,645	705	559.0	17,990	475	444.1	3,593	133	88.7	895	108	22.1	167	-11	4.1
1926 .	22,876	231	559.2	18,149	159	443.7	3,660	67	89.4	890	-5	21.8	177	10	4.3
1927 .	23,492	616	568.8	18,597	448	450.2	3,787	127	91.7	914	24	22.1	194	17	4.7
1928 .	24,382	870	584.2	18,997	400	455.6	3,912	125	93.8	1,267	353	30.4	186	-8	4.5
1929 .	24,877	515	580.9	19,391	394	460.6	3,941	29	93.6	1,322	55	31.4	223	37	5.3
1930 .	25,675	798	604.2	19,848	457	467.1	4,159	218	97.8	1,468	146	34.5	200	-23	4.7
1931 .	26,646	971	621.2	20,446	598	476.7	4,412	253	102.8	1,603	135	37.4	185	-15	4.3
1932 .	27,179	533	627.8	20,856	410	481.8	4,566	154	105.4	1,568	-35	36.2	189	4	4.4
1933 .	27,893	714	638.5	21,218	362	485.7	4,771	205	109.2	1,719	151	39.3	185	-4	4.2
1934 .	28,532	639	647.2	21,579	361	489.5	4,933	102	111.9	1,831	112	41.5	189	4	4.3
1935 .	29,172	640	670.4	22,033	454	506.3	5,009	76	115.1	1,927	96	44.2	203	14	4.6
1936 .	29,836	664	682.5	22,576	543	516.4	5,133	124	117.4	1,919	-8	43.9	208	5	4.7
1937 .	30,383	547	691.8	22,915	339	521.8	5,244	111	119.4	2,001	82	45.5	223	15	5.0
Average, 34 years .		(506)			(416)			(130)			(49)			(.8)	

¹ Population estimated for each intercensal year.² Includes Bridgewater and Tewksbury.³ Includes Veterans' Administration Facility No. 95 from April 25, 1924, and Veterans' Administration Facility No. 107 from August 11, 1928.⁴ Minus sign indicates decrease.

The average annual increase over the same period for patients within the state schools has been 130 patients per year.

For comparative purposes the rate per 100,000 of population, the population being estimated for intercensal years, is shown in table form for all hospitals, for state hospitals, and for state schools from 1904 to 1937 (page 130).

It may be said that in September, 1937, approximately 1 person out of each 145 residents of Massachusetts was a patient in a hospital or school under the supervision of the Department of Mental Health.

We have no desire to make the situation more serious than it actually is, but we feel that the Legislature should have as complete a knowledge of this general problem as the wise expenditure of 13 to 20 cents of each tax dollar demands. Let us see how good a job Massachusetts has been doing for the mentally ill and feeble-minded as measured by the yardstick of expenditures of money.

The latest comparative data available are from the publication, "Patients in Hospitals for Mental Disease, 1936," published by the United States Census Bureau in 1938.

In 1936 Massachusetts had a patient per capita cost per year of \$403.40, exceeded only by the District of Columbia at \$655.60, and the State of Wisconsin at \$432.50, per patient per year.

In this year Massachusetts had 476.2 patients per 100,000 of population as patients in state hospitals, the second highest rate in the country, being exceeded only by New York, with a rate of 480.3 per 100,000. Actually the rate for Massachusetts, as reported in the annual report of the Commissioner of Mental Health in 1937, including the mental wards at Tewksbury and the patients at Bridgewater State Hospital, was 516.4 per 100,000. There can be no question, then, that in comparison with other States Massachusetts has carried a heavy load.

In the census bureau statistics cognizance is taken of the percentage of overcrowding. These estimates of overcrowding are made by the individual States and represent the difference between rated bed capacity of the hospital and patients actually in residence. According to the United States Census Report for 1936 there was an average excess of population over capacity in Massachusetts state hospitals of 2,672 patients, or an overcrowding of the state hospitals of 15.6 per cent. This percentage of overcrowding was exceeded by nineteen other

States. In trying to evaluate this data it must also be considered that the standards set for the amount of space allowed per patient vary between States, and these data cannot be accepted as wholly comparable.

The number of deaths per 1,000 patients under treatment in state hospitals for the entire United States for 1936 was 71.9, for Massachusetts, 68.1. In general, then, the death rate is better than the average for the country, but sixteen States have somewhat lower death rates. The relatively low death rate is surprisingly good when consideration is given to the age of our patients admitted for the first time to the state hospitals. The following table will serve to introduce a problem which must be faced, namely, the great increase in the aged group who need hospital treatment:

First Admission of Patients to State Hospitals of the New England and Middle Atlantic States.

	MALE.			FEMALE.		
	All Ages.	Age 60 or Over.	Percent-age 60 or Over.	All Ages.	Age 60 or Over.	Percent-age 60 or Over.
<i>New England States.</i>						
Maine	245	79	32.2	203	56	27.5
New Hampshire	191	58	30.4	173	53	30.6
Vermont	154	29	18.8	104	32	30.8
Massachusetts	1,672	585	34.9	1,621	556	34.3
Rhode Island	206	50	24.2	162	49	30.2
Connecticut	719	207	28.8	534	137	23.7
<i>Middle Atlantic States.</i>						
New York	6,374	1,818	28.5	5,454	1,613	29.0
New Jersey	1,237	283	22.9	1,060	285	26.9
Pennsylvania	2,054	451	21.9	1,592	347	21.2

It is to be noted that a significantly higher number of elderly patients are being admitted to Massachusetts state hospitals than in the other States in this geographical area. More people are living to old age at the present time than was true three decades ago. This has been brought about by a lowering of the death rate among children. Researches are urgently needed in order to combat the steady increase in admissions of elderly patients to mental hospitals.

Let us combine the statistics on first admissions for the psychoses with hardening of the arteries of the brain and those due primarily to the ravages of old age — technically speaking, the psychoses with cerebral arteriosclerosis and the senile psychoses — for the past twenty-one years.

Number and Percentage of First Admissions suffering from Senile Psychoses and Psychoses with Cerebral Arteriosclerosis.

YEAR.	SENILE.		CEREBRAL ARTERIOSCLEROSIS.		BOTH.	
	Number.	Per Cent.	Number.	Per Cent.	Number.	Per Cent.
1917 . . .	258	7.0	261	7.1	519	14.1
1918 . . .	298	8.3	285	7.9	583	16.2
1919 . . .	291	7.8	294	7.9	585	15.7
1920 . . .	310	9.4	292	8.9	602	18.3
1921 . . .	336	9.7	272	7.9	608	17.6
1922 . . .	311	8.1	351	9.2	662	17.3
1923 . . .	250	7.1	375	10.7	625	17.8
1924 . . .	221	6.0	406	11.1	627	17.1
1925 . . .	287	7.5	434	11.4	721	18.9
1926 . . .	272	7.4	440	12.0	712	19.4
1927 . . .	270	7.0	461	12.0	731	19.0
1928 . . .	345	8.5	466	11.5	811	20.0
1929 . . .	287	6.9	526	12.7	813	19.6
1930 . . .	283	6.6	576	13.4	859	20.0
1931 . . .	275	6.1	658	14.5	933	20.6
1932 . . .	223	4.9	666	14.8	889	19.7
1933 . . .	258	5.6	720	15.8	978	21.4
1934 . . .	247	5.4	797	17.5	1,044	22.9
1935 . . .	290	6.0	767	15.9	1,057	21.9
1936 . . .	245	4.8	870	17.2	1,115	22.0
1937 . . .	302	6.0	853	17.1	1,155	23.1

In other words, since 1917 there has been almost a 123 per cent increase in the actual number of patients admitted to our state hospitals suffering from senile psychoses and with cerebral arteriosclerosis.

In another part of this report comment is made on the incidence of intemperance in patients admitted to the hospitals, and also to the steady increase in patients admitted because of mental disorder caused by alcohol.

On the other side of the ledger is the apparent decrease in mental disorder due to syphilis. With the nation-wide campaign so ably led by Dr. Parran of the United States Public Health Service, and with the continued advances in treatment and preventive measures, we can hope that a further reduction in mental disease due to this disease may be accomplished.

With this introduction we can now discuss the education, prevention and research phases of the problem of mental illness in Massachusetts.

The subjects of education, research and prevention of mental disease may be considered together. It is rather well known that the care of the mentally ill is primarily a problem for the state government to handle. At the present time more than 95 per cent of the hospitalization of the mentally ill in the United States is under governmental auspices. This being the case, the taxpayer who underwrites the cost of government is entitled to know how that portion of his tax dollar, allocated to the care of the mentally ill, is expended.

Section 3A, chapter 123 of the General Laws, defines the duties of the Department relative to mental health, and authorizes the Department not only to carry on research and inaugurate and prosecute preventive measures, but also to disseminate such information relative to the mental health of the citizens of the Commonwealth as it considers proper for diffusion among the people. Not only is it appropriate that educational efforts be made in regard to the general population, but efforts should also be made to educate the personnel within the institution and to disseminate information to the medical profession which may be of value in aiding the physicians to exercise preventive and curative functions in general. There are several very important reasons why information pertaining to mental disease should be disseminated among the people. Perhaps the most important, from the standpoint of preventive medicine, pertains to the so-called stigma attached to patients who have been so unfortunate as to have suffered from mental illness.

To partly explain this question of stigmatization, we should like to quote from a recent address given by Dr. Alan Gregg, director for the Medical Sciences, the Rockefeller Foundation:

Another obstacle for research in mental diseases deserves your attention and your understanding. Most diseases begin or show their presence first by changes, like pain, weakness, fever — pitiful and noticeable, but not morally alarming or socially dangerous.

But suppose a disease begins, with a loss of good judgment or self-control as the very first sign. What a confusion for all concerned! The disapproval and resentment we visit upon foolishness or immorality is immediately attached to such a disease. We may as well admit that it takes great self-control for healthy persons to follow the rules of civilized behavior, to say nothing of the difficulties of fulfilling the demands of Christian ethics.

If it happened that one of the first symptoms of a disease was not a chill or a headache, but a loss of self-control, how could we who are still struggling for self-mastery easily condone the sufferer's lapse? We should think he wasn't suffering — we should suspect he was enjoying it. Not until his misbehavior became unendurably flagrant would we concede that he was ill, and then, with almost uncontrollable aversion, we should put a taboo upon him and his disease.

Again, disease would be tainted with a moral flavor as it was in ancient India, or as it is among primitive peoples today. And thus would we forgo the moral credit of associating with such a sick man, and so lose the opportunity to be familiar with his disease. Now that is what happens in many mental diseases. From such circumstances comes a moral aversion amounting to horror of diseases that actually do show themselves in ways that break down social relationships, offend our moral sensibilities, our fastidious tastes, and our emotional equanimity. And so there is an immense taboo on mental disease, — a taboo resembling the savage's terror, and quite as inimical to observation, reasoning and study.

Happily and hopefully it is lifting, but let us understand that it exists and why it exists, for here especially we should recall the ancient "Ye shall know the truth and the truth shall make you free."¹

The "taboo" which Dr. Gregg emphasizes is generally spoken of as the "stigma" among patients and their relatives. It represents a throwback to medieval thinking. It is born of unreasoning fear, and it continues to live because of ignorance. People are ashamed to say that they have relatives who are mentally ill, or have been mentally ill, for fear that they, themselves, will be regarded as coming from poor stock. Of perhaps greater importance, potential employers are dubious regarding the advisability of employing former mental patients. Education of the general population may also be of significant help in reducing the incidence of necessary hospitalization. Two of the major types of mental illness, namely, the alcoholic psychoses and the psychoses with syphilitic meningoencephalitis — both are preventable. If there was no alcoholism and no syphilis there would be no mental illness due to these two

¹ Mental Hygiene, Vol. 23, January, 1939.

conditions. On the other hand, the psychoses due to syphilis are gradually decreasing. The decrease in the incidence of mental disorder due to syphilis has been brought about partly through educational propaganda of the type inaugurated by Dr. Parran of the United States Public Health Service, and partly through the results of scientific research.

It was not until 1911 that it was known for a certainty that the psychosis now known as syphilitic meningoencephalitis was actually due to the action on the brain of the germ causing syphilis. The discovery by Noguchi and Moore of the *Treponema pallidum* in the brains of patients dying from general paresis, or, as it is now known, syphilitic meningoencephalitis, was the clinching evidence needed to make the causative factor of this condition a certainty. Research has been the second great factor in the reduction of the syphilitic psychosis. The discovery of the Wassermann test, which will indicate the presence of syphilis by an examination of the blood, the development of compounds of arsenic that could be injected into the veins of a person, thus killing the germ of syphilis without injuring the person suffering from syphilis, represented another step in advance. Later, research developed even better methods of treatment.

The discovery by Wagner von Jauregg of the curative value of elevating the temperature of the patient suffering from neuro-syphilis by means of inoculation with malaria represented a still greater advance in treatment. At the beginning of this century the mortality rate of syphilitic meningoencephalitis was tremendously high. Very few of the patients suffering from this condition lived more than six months after admission to our mental hospitals. Without treatment, this particular disease is a killing disease, and is steadily progressive in the great majority of cases. Still later came more refined methods of treatment. The ability to elevate the temperature of the body by electrical means also proved of value in the treatment of central nervous system syphilis. It may be pointed out that Wagner von Jauregg received the Nobel prize in medicine for his discovery that artificial inoculation with malaria had a curative effect in neuro-syphilis in a fairly high percentage of cases.

We have touched lightly upon the research aspects of only one mental disorder merely to show the importance of research and what may be expected from the expenditure of money in this direction. To again quote Dr. Gregg:

The mere existence of research work in a mental hospital improves the care given all the patients. They are seen more often — some are watched far more attentively. It is like introducing accounting in a business house. Records are kept. Failures are recognized and reported. This you are accomplishing wherever your fire has lit the investigator's lamp. You are giving encouragement to those medical scientists and physicians who have wanted to do research work. You have encouraged some younger men to prepare themselves for careers in psychiatric research.

To further quote from Dr. Gregg, who is perhaps in the best position of any man in the United States to know the policies of great foundations in rendering grants in aid available for researches:

I know of no foundation whose trustees would continue to vote funds if they thus eliminated the interest and collaboration of others. Indeed, most foundation grants are made on the condition that funds be obtained from other sources on a one-to-five or a fifty-fifty or an eighty-five-to-fifteen ratio. Many is the time I have seen a private donor unlock with a relatively small sum a large foundation grant which was conditional upon his measure of collaboration.

Dr. Gregg goes on to say:

If research in mental disease is to attract fine research minds, and if it is to be successful, time is needed, not merely increased funds. Fifty thousand dollars a year for ten years in superior hands is usually better than a million over a two-year period in the same hands. Tenacity of purpose and seriousness of intent are worth more than princely but wavering generosity, because the test of time must be met by any theory of cause or method of cure. Brilliant ideas need stages of trial and development as well as mere initiation. You must be patient and long-suffering in this task; the sick you seek to aid have long been that. . . . And may I suggest that some of you have the courage to inquire in your own States what is the budget for study and continuing search beyond the causes of the mental disorders for which such huge sums are being spent? Or to visit the institutions and see what a sad state of human suffering your funds are spent to render needless?

The State of Massachusetts has for many years been in the forefront in the matter of investigation of mental illness. For many years the Department has had a Division of Mental Hygiene whose primary duties are the responsibility for conduct of preventive measures and research. In 1936 and 1937 the National Committee for Mental Hygiene conducted a survey and tentative appraisal of research activities, facilities

and possibilities in state hospitals and other tax-supported institutions for the mentally ill and defective in the United States. A quotation from the report of this committee and the significance of research in public institutions is germane.

The appropriateness of looking to our publicly supported hospitals for investigatory work is evident when we take into account the vast patient populations now resident in these hospitals that offer unrivalled opportunities for observation and study. And in contributing to an enlargement of knowledge in the psychiatric field, staff members become imbued with a scientific spirit that is reflected in better clinical work. It is a matter of observation that without research, any clinical group of workers tends to drift into a scholastic attitude in which the opinions of former authorities are substituted for actual observation and frequent reorientation. On the other hand medical groups that have one or more members working on some research project are stimulated to a greater alertness and usefulness to their patients. It is also worthy of note that the task of recruiting promising men for mental hospital posts is facilitated if there can be held out the inducements of clinical work that is not routinized and, in addition, opportunities for investigatory efforts.

Excerpts from the summary of findings of this committee are given.

Twenty of the 273 public institutions can be designated as research centers because of the character and quality of their investigatory work, the caliber of their personnel, and the resources at their disposal for scientific studies.

In addition to these twenty centers there are thirty-two publicly supported hospitals that offer distinct possibilities for research work, judging by the advantages they enjoy in the way of basic facilities that lend themselves to investigate activities.

It is noted that research interest is most marked in the Middle Atlantic, New England and North Central States.

It is estimated that not more than two or three million dollars are expended annually for psychiatric research in the United States, and that of this amount more than one half is derived from foundations, individuals and private agencies.

As a result of this survey superintendents stated that the chief deterrents to the prosecution of research in mental hospitals are . . . inadequate staffs, remuneration insufficient to attract the best men, difficulty in securing facilities, and lack of funds for investigatory purposes. All agree that research activities in hospitals tend to quicken the scientific interest of the staff, thereby improving the care and treatment of patients.

It is considered significant that in twenty-one hospitals the research facilities were being used by outside groups. The committee reported that "although there is a vast field for research in mental deficiency and convulsive disorders, there is a dearth of interest in investigative work in mental institutions devoting attention to these conditions." Those connected with the aforementioned study were convinced that "a signal contribution might be made in placing mental hygiene and psychiatric research on a firmer and more productive basis in this country if a capable group of scientists having access to research funds could devote attention to strengthening the twenty research centers to facilitate the training of research personnel for other hospitals; collaboration with the thirty-two potential centers to foster investigatory work; securing greater recognition for psychiatric research as a matter of public policy in the more progressive States; fostering closer affiliations between mental hospitals and medical schools; and recruiting promising young scientists in the field of psychiatry."

It must be a satisfaction to the citizens of Massachusetts to know that as a result of this impartial investigation on the part of the National Committee for Mental Hygiene it is found that four of the twenty leading research centers in mental disease in the United States are located in Massachusetts. These institutions are the Boston Psychopathic Hospital, Boston State Hospital, Worcester State Hospital and Wrentham State School. There are more leading research centers in Massachusetts than in any other State. This is indeed an enviable position, and every effort should be made to retain this lead. The summary of the report of the Committee on Research Center and Methods submitted to the Special Commission is appended as Section C of this Appendix.

In general, the Special Commission on Mental Diseases is in agreement with the fundamental policies outlined in this report. However, the mechanics of how the results desired by the Committee on Research are to be accomplished is a matter which should be left to the discretion of the Department of Mental Health.

In the question of education, a general policy of education of the general population should be followed by the Department of Mental Health, with the basic object in mind of doing away in Massachusetts with the feeling of stigmatization on the part of patients in our mental hospitals and their relatives.

Many people in our Commonwealth know that there is no sound reason for this feeling of stigmatization. It should be an objective of the Department to further dispel ignorance in this matter. This can be accomplished by a state-wide policy of educating the people by means of all sixteen institutions working on the matter under the direction of the Department of Mental Health, together with private individuals and organizations.

The most vital problem in connection with the major problem of mental health in our State is the question of personnel. Given the proper type of personnel, solutions of practically all of the problems under discussion will be forthcoming. It is essential and imperative that the staff members in the various state hospitals receive proper instruction. The relationships of the doctor to patient and doctor to relative is particularly important in dealing with the problems of mental illness. There is a very large demand for properly trained professional personnel. This has always been a problem in mental hospitals. Superintendents of institutions point out that in the past, when times were good, economically speaking, it was very difficult to obtain personnel with high qualifications. When times became bad the mental hospital staffs improved. Naturally, there were many exceptions to this rule.

The importance of psychiatry has received appropriate attention in medical schools only in recent years. The importance of this problem has been a matter of concern of the National Committee for Mental Hygiene for many years, and there is a division of psychiatric education which is responsible for the entire matter of education. Indeed, one of the general purposes of the National Committee for Mental Hygiene is developing trained personnel in the field of psychiatry and mental hygiene. Massachusetts in its state hospital system has trained a large number of physicians in psychiatry, who, after receiving their training, have either gone to private practice or have entered the field of psychiatry in other States. It is perfectly true that mental illness, like other illness, has no geographical boundaries, and that any policy restricting the training of psychiatrists in the Massachusetts system, for service only in Massachusetts, would be shortsighted so far as the public health of the nation is concerned. Certain States do not have the educational facilities that exist in Massachusetts, New York, Illinois, Pennsylvania and some of the other

larger States. It would seem, then, that our State has a certain national, as well as state, responsibility. Doctors, after they have received their medical school training, are not qualified to practice psychiatry without further training. The best places in which this training can be obtained to permit qualification as psychiatric specialists are in state hospitals, psychopathic hospitals and the larger private mental hospitals.

Well-founded opinion has been presented to the Special Commission that the system of training in vogue in the Massachusetts system at the present time could be changed to the advantage of the potential psychiatrist. At the present time the training of the majority of our state hospital physicians is obtained within the institution to which the potential psychiatrist is attached as a staff member. The actual details of how the training program for staff members is carried out is left to the Department of Mental Health and the institutions under its control. Strong recommendations have been made to the Commission that some such educational program as follows might be considered and possibly put into effect in the immediate future:

That minimum standards should be established; that all potential staff members should be graduates of acceptable medical schools; should have had general hospital internships; and that a new grade for psychiatric trainees should be established at a slightly lower salary than that given the assistant physician at the present time.

It would seem that such a reduction in salary is justified during a training period. During the training period the psychiatric interne should be under the administrative control of the Department of Mental Health, and should receive basic training in perhaps four acute receiving hospitals in which the staffs are well qualified to teach.

The curriculum for the basic psychiatric instruction should include, in addition to clinical psychiatry, a certain amount of clinical neurology, psychology, psychometrics, bio-chemistry and general pathology of mental disease, psycho-biology and psycho-pathology. *All of the subjects that the American Board of Psychiatry and Neurology examines candidates in should be included in the curriculum.* Additional subjects to be taught should be added in the discretion of the teaching faculties, with the approval of the Department.

One institution would probably be unable to carry the teaching load necessary for replacements in the Massachusetts state system. With a well-qualified professional personnel one can constantly expect resignations from staff members, due to better opportunities, vacancies caused by promotions, and resignations due to various reasons. For this reason it is felt that several institutions should be approved

for special training. In addition to the intramural psychiatry, special training in the treatment of the epilepsies should be given at Monson. Special training in the treatment of feeble-minded should be given in one of the schools for the feeble-minded. Special training in caring for the neuroses should be given in the adult out-patient departments of selected institutions. Special training should be given in the examination of retarded children in the traveling school clinics. Experience should be given in the examination of prisoners toward the latter part of the period of training. A period of not less than three months' training should be given in child guidance clinics and habit clinics.

It has been called to our attention that candidates for certificates from the American Board of Psychiatry and Neurology, who have been employed for long periods of time in the schools for the feeble-minded, are examined to a large extent in the psychoses only. It is the opinion of the Commission *that both the schools and the hospitals might profit by an "exchange" system of staff members who have been in the service perhaps for some time.* This would serve to give a given institution the benefit of the viewpoint of the staff member working on an exchange basis from another type of institution.

The Commission also approves of the idea of international exchange arrangements, tending, as it may, to render less provincial the individual staff members as a result of their international contacts. The viewpoints of the different staffs should be stimulating.

It is fully understood by the Commission that training, extending possibly over a two-year period, will not produce a specialist in psychiatry. It is definitely felt, however, that such training would be markedly superior to that given in any institution in Massachusetts at the present time. It is further suggested that with a well-organized course which might well be given under the combined ægis of one of the medical schools and the Department of Mental Health, in collaboration with the institutions under its jurisdiction, an advanced degree might be granted which would be an additional inducement for men of outstanding ability to enter the psychiatric field.

At this point we call attention to an interesting suggestion which has been made, namely, that every institution should have a clinical director. The clinical director should have, among his other duties, the major responsibility for the teaching of subordinate staff members within his institution. His qualifications should be so outstanding that there could be no

question regarding his professional leadership within a given institution. The salary of the clinical director should be commensurate with his responsibilities. Such an arrangement might induce particularly able psychiatrists to remain in the clinical field rather than to shift their interests to the administrative field. In other words, the clinical field would be made sufficiently attractive, financially, to warrant the psychiatrist staying in that field. Many of the staff members in the Massachusetts state hospital service have been in the service for many years. There is a tendency for some institutional staff members to get into a "rut" and remain content with treatment and diagnostic methods which are obsolete. It is the feeling of the Commission that measures should be taken to prevent such tendencies toward lack of progressiveness. It is suggested that every five years all staff members be encouraged to take a three months' "refresher course."

In the interests of maintaining and increasing the standards of professional attainment, it is suggested that all staff members in the Massachusetts state system, who have attained the service time requirements of the American Board of Psychiatry and Neurology, be required to obtain a certificate from that Board within two years of attaining the time qualifications. In other words, all physicians who have been in the service for periods of over eight years shall be required to hold a certificate as a specialist in psychiatry. The present courses which for the last several years have been given at the Metropolitan State Hospital, in preparation for examination for the American Board of Psychiatry and Neurology, should be continued.

A psychiatric symposium which was held during the past year in one of the hospitals seemed to prove very stimulating and satisfactory. *Similarly arranged symposia should be given as frequently as material worth reporting accumulates.* Along this line it is felt that *the old association for assistant physicians should BE REVIVED.* This would tend to break down the traditional isolation of the institutional psychiatrist, and would give him the opportunity of finding out how various problems are handled in the different institutions coming under the system.

It is felt that such an arrangement would be stimulating to the various staff members, provided suitable demonstrations were arranged and opportunity was given for interchange of ideas among the various staff members.

There is available in the state hospitals of the Commonwealth a large amount of clinical *neurological material*. It is felt that this material *could be utilized to far greater advantage than perhaps has been the case in the past*. Some change of personnel in the state hospitals and schools is a healthy sign. One of the best outlets for men who are leaving the state service is the private practice of neurology and psychiatry. This being the case, facilities available for the clinical teaching of neurology should be utilized as much as possible.

In addition to the educational suggestions made above, we should like to see the Department Bulletin revived so that the staff of one hospital will know in a general way what is happening in the other hospitals. We understand that many of the physicians in the state service would not write articles for the Bulletin because they believed that the circulation of the Bulletin was small and that their productions would be "buried" in the publication. The format of the Bulletin was not too satisfactory. The print was very small and the "general set-up" was not good. We believe that the format of the Bulletin should also be changed for psychological reasons, and, in general, that it should be completely revived. It is felt that with a Bulletin coming out quarterly a great deal of good would be accomplished, particularly if the editorial board was truly representative, not only of the Department, but also of the institutions coming under its jurisdiction. In order to accomplish this aim, however, the expense of operating the Bulletin would have to be markedly increased. Few will read the Bulletin in its present format. We are of the very definite opinion that sufficient funds should be made available for the Department to publish a Bulletin in such form that it can be widely disseminated and read. It is the opinion of the Commission that legislation should be passed permitting advertising in this journal, and permitting a paid circulation. This procedure has already been followed in the State of New York and the journal has a great following.

Any profits obtained from advertising in the Bulletin should be used to expand future issues of the publication, and if the advertising revenue warrants the issuance of a publication similar to the "house organs" used by commercial companies, for distribution to the Department and hospital personnel, the publication could also be available to the public, and in this way would be a decided help to the Department in its program to educate the public regarding its work.

It is believed that the circularization of medical reprints by the Division of Statistics should be continued. This method serves to call to the attention of the individual physician reprints of great medical importance.

Of the most vital importance in the question of education of staffs is the establishment in each hospital of a first-class medical library. A good library, in all probability, can do more in the way of improving the caliber of medical treatment than any other single factor. Sufficient money should be made available to each of the institutions to permit adequate library facilities. The medical books are the tools of the doctor. The best way to keep abreast of the medical times is for the doctor to read his medical journals and to attend his medical meetings. We believe that all staff members should be encouraged to acquire membership in their state and national, medical and psychiatric societies, and membership in these societies should be taken into consideration in the rating of individual staff members. It is further believed that the Department should inaugurate a policy of paying the expenses of all staff members presenting technical papers before national society meetings. Not only would such a policy stimulate staff members to produce original work, but, what is as important, it would give them an audience for constructive criticism. The payment of expenses should be limited to original contributions. For physicians who are interested in progressing along the administrative rather than the clinical route, steps should be taken for the inauguration of courses in administrative procedures. All physicians with the grade of assistant superintendent, who aspire to the grade of superintendent, should have taken basic courses in business administration. These courses can be acquired through any of the larger universities or the University Extension Courses.

The relationships with the various medical schools should be strengthened by continued affiliations with the schools through teaching. Staff appointments in the medical schools should be encouraged, and time for the giving of lecture courses in medical schools should be granted without loss of pay. Such teaching affiliations should be encouraged. Generally speaking, the teaching institution is the best institution. Affiliations with leading general hospitals for the training of medical internes should be encouraged. The entire question of psychosomatic relationships is being considered more and more important in recent years. The development of these extramural

contacts on the part of state hospital physicians is of vital importance in the preventive field. Unless medical students and physicians in general practice receive proper instruction in psychosomatic medicine, little can be hoped for in the way of preventive psychiatry.

It is perfectly true that the bulk of sick patients are seen first by their family doctor. It is unfortunately true that instruction in psychiatry in most medical schools, even at the present time, is considered relatively meager.

What has been said relative to instruction of intramural professional personnel is equally applicable to the ancillary services.

Instruction for attendants and nurses, affiliated, undergraduate and graduate, should be greatly strengthened. It is the opinion of the Commission that the instruction of these groups would result in an improvement of the care given our mental patients. Special instruction should be given to occupational therapists, students in training for psychiatric social work, and other allied disciplines.

In short, and to a very large extent, the future of preventive work in the field of psychiatry is to be hoped for through the medium of educational efforts directed toward (1) the general population, (2) the medical profession, including the staffs of mental hospitals, (3) the medical student, and (4) psychiatric ancillary disciplines.

The Division of Mental Hygiene was organized to fulfill the provisions of section 3A, chapter 123 of the General Laws. The Division of Mental Hygiene Report for the Commission (page 157) relates briefly the developments of the Division since its organization. In this report attention is called to the fact that "the most important aspect of research of any type is personnel, and it soon became obvious that those best equipped by education, training and experience were already participating in activities of various kinds which would not permit their being employed on a full-time basis by the State. The question of adequate compensation would have also prevented the plan." The plan as developed has been demonstrated to be very productive, and we believe that the part-time employment of research personnel is warranted.

The relationship between the Department of Mental Health and the Massachusetts Society for Mental Hygiene continues cordial and co-operative. In addition to the educational efforts of the Division of Mental Hygiene, we are informed that the Superintendents' Committee on Public Relations and Scientific

Publications is reviewing the entire matter of public education in the State with a view to making recommendations for any additional action needed in regard to educational efforts directed toward the general public. All legitimate educational and co-operative devices should be used by the Department in its educational program, constituting as it does part of the larger preventive program. These efforts should be addressed to private practitioners of medicine, to teachers and psychologists. Emphasis should be placed on educational material of proven worth of a utilitarian nature. Efforts should be made as soon as possible to evaluate as well as possible the contribution of the child guidance and habit clinics. Material of proven value should be disseminated among the medical profession and other agencies which can exercise preventive measures.

Consideration should be given by the Department to the establishment of adult psychiatric clinics in cities of over 100,000 population. Such clinics could be operated as a joint enterprise with local departments of public welfare. Such clinics are now in operation in the city of Worcester with apparent success. Care should be taken that only patients who are unable to pay for private psychiatric care be treated in such clinics. Private general hospitals should be encouraged in so far as is possible by the Department to operate psychiatric departments. The Massachusetts General Hospital has broken the ice in this State, and if other general hospitals should open such departments there would doubtless be a lessening of the attitude of stigmatization on the part of the uninformed public that now so unfortunately exists. A greater utilization of the voluntary form of commitment in Massachusetts is another matter which is deserving of serious consideration, particularly on the part of the hospital superintendents.

The following description of the activities of the habit clinics is taken from the Report of the Division of Mental Hygiene for 1937, written by Dr. Douglas A. Thom:

The clinics maintained by the Division continue to stress the quality of the work rather than quantity. The careful study of the problem and treatment of the individual child has been the objective, and we have avoided any procedures that would tend to defeat this aim or lower the standard of the service rendered to the public. While not being disposed to limit our intake of cases, we have endeavored to keep the number accepted for intensive treatment consistent with highest therapeutic standards. Clinics maintaining such aims and standards cannot undertake to study intensively all of the cases

referred — to do so would naturally reduce the number of cases that could be accepted for treatment as well as impede progress in those cases where service is most needed. Therefore it is necessary to select wisely those cases for prolonged study and treatment. This selection is not made on any arbitrary basis, or by avoiding the challenge which the most difficult cases offer when it is deemed practicable to do so. Rather, the selection is made on the basis of whether a child will be benefited by the specialized type of service we have to offer, and whether therapeutic effort is likely to be a prudent expenditure of time and money. Every case referred is accepted for appraisal at least, if not for detailed study and treatment. In those cases where a complete clinic service would seem to be impractical (either from the patient's standpoint or from that of the clinic), a consultation service is always rendered in which an appraisal of the case is given to the referring agency, with recommendations made as to the most practical disposition of the case.

Because such frequent inquiries are made both by correspondence and by personal visits from interested persons regarding clinic service, a brief résumé of the clinics' mode of operation would seem appropriate at this time. Children are referred to the clinics from various sources and for many reasons: behavior problems as related either in the home or outside; personality deviations so marked as to interfere with social and scholastic adjustment; various neurotic traits; educational disabilities in the form of inability to read; difficulty in concentration, and application interfering with school progress; and lastly, problems of delinquency. The variety of problems and situations brought before the clinics necessitates a comprehensive method of study. This is outlined briefly in the following description of clinic routine:

The clinic procedure is devised on the assumption that a child who presents difficulty in the home, school or other contacts, or manifests symptoms or signs of disturbance in the course of physical and mental development, requires a thorough study in order to determine the real sources of his difficulty. The full study of the child begins with a careful physical survey, except where recent and adequate reports of physical examinations are available. Physical defects or disease must be carefully evaluated in any psychiatric program which is to be outlined. In some cases where physical factors are found to be acute and predominantly the causative factor in the particular problem for which the case was referred, the habit clinic may act in an advisory capacity to the pediatrician; in others, the psychiatric program may proceed simultaneously and co-operatively with the medical program.

The psychological study of the child is the next step. This includes an evaluation of his intellectual capacity, his school achievement, and his special abilities and disabilities. The psychologist's contribution to our knowledge of the child's intellectual development

is important, and offers a basis for planning his educational program and his school placement. In addition to this, the psychologist's observations of the child during his period of study aids appreciably in obtaining a better understanding of the child's personality.

A detailed study of the child's environment is made by a psychiatric social worker. This information is obtained from one or both parents, from the physician, and from teachers and others familiar with the child and his varied environments. It includes a complete picture of the family situation; a detailed developmental and medical history; a record of the child's adaptation to the school, both as regards his scholastic achievement and his adjustment to the teacher and the pupils, as well as his behavior in the play group. The completed study is a picture of environmental background and the child's relationship to parents, teachers, siblings and others.

The psychiatrist then acquaints himself with the child and the parents, as well as with the data already collected by the other staff members co-operating in the case. The psychiatrist's study begins with an observation of the child's behavior in the examining room, and goes on to a more intensive investigation of his emotional drives, interests, attitudes, personal relationships and his mental attitudes toward life in general, and specifically toward the problem for which he was referred.

In dealing with children of pre-school age, psychiatric inquiry and therapy are directed frequently more to the parent and the environment rather than to the child himself. We know that many of the difficulties of these younger children are but secondary to the problems of the parents.

The next step in clinic routine is the summarizing and co-ordinating by the psychiatrist of all the information and impressions obtained by staff members preparatory to a staff discussion. Physicians, teachers, social workers and others interested are invited to discussions. The case is reviewed, the observations of the various staff members reported and discussed, a diagnostic summary made, and plans for treatment outlined.

Treatment varies with the individual case, and it is impossible in a report of this nature to adequately discuss the question of treatment of the social, educational, psychological and psychiatric problems. However, one might roughly list treatment procedures as follows:

1. Direct information and advice to parents and teachers.
2. Direct application of remedial procedures appropriate to specific needs of the child.
3. Direct psychotherapy with the child.
4. Psychotherapy for the parent.
5. Social treatment for the environment.

Any one or several of the above approaches to the child's problem may be undertaken by one or more members of the clinic staff, frequently in co-operation with the school, or social agency interested

in the case. A portion of therapy consists of parental education and environmental reconstruction, excepting in those cases where we are faced with a situation in which the problem is a fundamental one, involving the whole organization of the personality and character of the child. The difficulties encountered in attempting to influence the fundamental personality organization of an individual are many and varied. However, with the knowledge available regarding the nature of the influences that determine personality and character, it is possible in certain cases to evaluate what is taking place in the mental life of these children. Not infrequently we see the gradual development of the potential neurotic, eccentric, delinquent and psychotic adult, and it is in these cases where we should eventually find possibilities for fruitful preventive work. Some of our most interesting, as well as our most challenging cases, fall within this group.

For the more serious personality problems we have made a systematic and concerted effort at treatment. Our objective has been to facilitate the child's emotional, intellectual and social development in order that he may attain a more satisfactory adjustment to life.

The following tables show the total case load for the various habit clinics and the sources of the new cases, and types of service rendered as well as more detailed information on special service:

HABIT CLINICS.

Total Case Load showing Number of New and Old Cases attending Clinic, Number of Visits made by Children to Clinic, and Number of Clinic Sessions, December 1, 1936, to November 30, 1937.

	Case Load.	Number of Children attending Clinic.	New Cases attending Clinic.	Old Cases attending Clinic.	Visits to Clinic by Children.	Number of Clinic Sessions.
Total	1,136 ¹	1,024	724	300	4,185	424
Boston Dispensary .	187	164	131	33	458	94
Lawrence	153	139	90	49	719	47
Lowell	80	71	49	22	262	48
New England Hospital	154	130	96	34	385	45
North Reading . .	29	23	23	-	29	9
Norwood	107	103	70	33	438	46
Quincy	234	212	145	67	888	44
Reading	50	44	34	10	191	43
West End	142	138	86	52	815	48

¹ The first column includes 112 old cases that were active with social service, but did not return to clinic.

HABIT CLINICS — *Continued.**Sources of New Cases, December 1, 1936, to November 30, 1937.*

	Total New Cases.	Schools.	Health Agencies.	Friends and Relatives.	Physicians.	Children's Agencies.	Family Agencies.	Community Education.	Clinic Staff.	Settlements.
Total	724	257	246	101	36	28	28	20	7	1
Boston Dispensary	131	3	119	6	—	2	1	—	—	—
Lawrence	90	44	8	16	13	5	3	1	—	—
Lowell	49	14	4	6	5	2	4	14	—	—
New England Hospital	96	12	42	16	6	9	8	3	—	—
North Reading	23	—	23	—	—	—	—	—	—	—
Norwood	70	55	1	10	1	—	3	—	—	—
Quincy	145	84	20	23	6	4	3	2	3	—
Reading	34	21	2	7	1	1	—	—	2	—
West End	86	24	27	17	4	5	6	—	2	1

Types of Service rendered, December 1, 1936, to November 30, 1937.

	Total Case Load.	FULL SERVICE.			SPECIAL SERVICE.		
		Total.	RESPONSIBILITY.		Total.	RESPONSIBILITY.	
			Clinic.	Co-operative.		Clinic.	Co-operative.
Boston Dispensary	187	133	130	3	54	48	6
Lawrence	153	105	104	1	48	43	5
Lowell	80	56	55	1	24	22	2
New England Hospital	154	140	140	—	14	14	—
North Reading	29	9	7	2	20	—	20
Norwood	107	80	80	—	27	27	—
Quincy	234	158	158	—	76	75	1
Reading	50	40	40	—	10	10	—
West End	142	122	122	—	20	17	3
Total number of cases	1,136	843	836	7	293	256	37
Percentage of totals	100	74	73	1	26	23	3

HABIT CLINICS—*Concluded.*

*Types and Number of Cases given Special Service, December 1, 1936, to
November 30, 1937.*

Total number of cases receiving special service	293
1. Diagnosis and consultation requested	79
2. Complete investigation not necessary for treatment	23
3. Complete investigation not practicable	25
4. Family history already known to clinic	15
5. Cases referred to another clinic or agency	15
6. Patient's problem ceased after one visit to clinic	9
7. Family not interested in clinic treatment	50
8. Social situation too poor for patient to profit from clinic treatment	8
9. Patient too retarded to benefit by clinic treatment	69

The following table presents the type of clinic in operation at the various institutions under the Department of Mental Diseases during the year 1937:

Number and Type of Clinics in Operation under the Department of Mental Health during the Year ending November 30, 1937.

INSTITUTION.		TYPE OF CLINIC.						Total.
		Child Guidance.	Habit.	Juvenile Court.	General Out-Patient.	Mental or Mental Hygiene.	Traveling School Clinic.	
<i>Hospitals.</i>								
Psychopathic . . . . .	.	-	-	-	1	1	1 in 2 towns	3
Boston State . . . . .	.	-	-	1	-	-	1 in 3 towns	2
Danvers . . . . .	.	6	1	1	1	1	1 in 36 towns	11
Foxborough . . . . .	.	-	-	-	1	2	1 in 23 towns	4
Gardner . . . . .	.	4	-	1	2	-	1 in 29 towns	8
Grafton . . . . .	.	-	-	1 ¹	1	-	1 in 19 towns	3
Medfield . . . . .	.	1	-	2	-	-	1 in 17 towns	4
Metropolitan . . . . .	.	1	-	-	-	-	-	1
Monson . . . . .	.	1	-	1	1	-	1 in 8 towns	4
Northampton . . . . .	.	2	-	1	1	8	1 in 42 towns	13
Taunton . . . . .	.	-	-	-	1	3	1 in 56 towns	5
Westborough . . . . .	.	1	-	1	1	4	1 in 5 towns	8
Worcester . . . . .	.	1	-	-	1	1	1 in 47 towns	4
<i>Schools.</i>								
Belchertown . . . . .	.	-	-	1 ²	1	-	1 in 37 towns	3
W. E. Fernald . . . . .	.	-	-	1	1	-	1 in 13 towns	3
Wrentham . . . . .	.	-	-	1	1	-	1 in 15 towns	3
Division of Mental Hygiene . . . . .	.	-	9	-	-	-	-	9
Total . . . . .	.	17	10	12	14	20	15	88

¹ By appointment in Hudson, Leominster, Milford, Natick, Whitinsville, Blackstone, Uxbridge.

² By appointment in Adams, Franklin, Greenfield, Holyoke, Ware, Williamstown.

The following table outlines the number of examinations by the various clinics under the Department during the year 1937. We observe that a total of 16,324 persons were examined by the various clinics operating in 1937. It is interesting to note that the greater part of these examinations were of individuals under 16 years of age. Of the total, 12,289 were under 16 years of age and 4,035 were 16 years of age or older. Of this grand total of 16,324, 11,341 were new cases or first examinations, and 4,983 were cases which had been seen previously and had returned to clinic for another examination.

Of the total examined, 750 were examined by child guidance clinics; 1,057 by the habit clinics; 923 juveniles were examined in connection with the Juvenile Court work; 2,739 were seen in the general out-patient clinics and 2,550 in the mental hygiene clinics. The largest number were examined by the fifteen traveling school clinics which operate throughout the public schools of the State. Here we have a total of 8,305 children examined during the year.

At the bottom of the table we note several percentages in connection with the patients under 16 years or over 16 years. Of persons being examined for the first time, 84 per cent were under 16 years and 15 per cent, 16 years or over. Here we have an example of the mental hygiene implications in these various clinic examinations. Roughly, five out of every six persons examined by a clinic under the Department of Mental Diseases are found to be under 16 years of age. In re-examinations we note, as might be expected, that the older individuals are appearing more frequently for additional psychiatric advice. In the re-examinations but 54 per cent are under 16 years, while 45 per cent are over 16 years. If we consider first and re-examinations together, we observe that 75 per cent of persons coming up for psychiatric advice are 16 years of age and younger, and 25 per cent are 16 years of age or older.

*Number of Examinations conducted by Clinics of Institutions under the Department of Mental Diseases during the Year ending
November 30, 1937.*

[By type of clinic and age.]

TYPE OF CLINIC.	FIRST EXAMINATIONS.			RE-EXAMINATIONS.			GRAND TOTAL.		
	0-15 Years.	16 Years or Over.	Total.	0-15 Years.	16 Years or Over.	Total.	0-15 Years.	16 Years or Over.	Total.
Child guidance	600	30	630	118	2	120	718	32	750
Habit clinics	757	-	757	300	-	300	1,057	-	1,057
Juvenile Court	659	253	912	8	3	11	667	256	923
General out-patient	1,110	652	1,762	109	868	977	1,219	1,520	2,739
Mental or mental hygiene	168	846	1,014	155	1,381	1,536	323	2,227	2,550
Traveling school clinics	6,266	-	6,266	2,039	-	2,039	8,305	-	8,305
Total	9,560	1,781	11,341	2,729	2,254	4,983	12,289	4,035	16,324
Per cent	84.2	15.7	100.0	54.7	45.2	100.0	75.2	24.7	100.0

B. DIVISION OF MENTAL HYGIENE REPORT FOR THE
SPECIAL COMMISSION.

The act establishing the Division of Mental Hygiene, which was approved June 8, 1922, stated:

The department shall take cognizance of all matters affecting the mental health of the citizens of the commonwealth, and shall make investigations and inquiries relative to all causes and conditions that tend to jeopardize said health, and the causes of mental disease, feeble-mindedness and epilepsy, and the effects of employments, conditions and circumstances on mental health, including the effect thereon of the use of drugs, liquors and stimulants. It shall collect and disseminate such information relating thereto as it considers proper for diffusion among the people, and shall define what physical ailments, habits and conditions surrounding employment are to be deemed dangerous to mental health.

The act as originally written gave such scope to investigations and researches that there has been no need for change during the past fifteen years, and much remains still to be accomplished in carrying out the provisions of the act. The basic and fundamental purpose which prompted the creation of the Division of Mental Hygiene was to permit and encourage research in the field of mental disease, and to provide adequate facilities for the diagnosis and treatment for the early and incipient cases of mental illness, with the ultimate objective of affecting in some measure, at least, the ever-increasing influx of mental patients to our state hospitals. With that fundamental idea in mind, the work of the Division quite naturally divided itself into two major activities: (1) research work of the laboratory type in neuropathology, physiology and pharmacology, supplemented by clinical investigations with patients already in state institutions, and (2) the organization and development of adequate clinical facilities throughout the State for the purpose of permitting those suffering from incipient mental disorders to have the same opportunity for consultation and treatment as those individuals suffering from physical disorders, and for the first time this clinical service was extended to include children with undesirable habits, personality disorders, and delinquent trends, all of which bear a close relationship to the maladjustments of later life.

It seemed wise at the time the Division of Mental Hygiene was created (as it still does to the Director) that the ultimate

responsibility of both the research of the laboratory type and the organization of the clinical facilities of the community be delegated to the twelve state hospitals and the three schools for the mental defectives situated throughout the State, and that the interests of both the clinical and the laboratory work would be best served by the Division of Mental Hygiene stimulating and co-ordinating the various activities throughout the State, giving particular attention to those centers where help was most needed.

The most important aspect of research of any type is personnel, and it soon became obvious that those best equipped by education, training and experience were already participating in activities of various kinds which would not permit their being employed on a full-time basis by the State. The question of adequate compensation would have also prevented such a plan. The Director found no difficulty, however, in interesting a limited number of qualified physicians to engage in directing research activities and to get the co-operation of those already employed by the State. Drs. Harry C. Solomon, Abraham Myerson, Oscar J. Raeder, Myrtelle Canavan and Paul Yakovlev are some of the outstanding physicians who have co-operated and contributed to the research work.

In the organization and development of the clinical facilities, the staffs of the various state hospitals were found adequate to deal with the incipient mental illnesses of adult life. It was, however, necessary to start the training of an entirely new group of psychiatrists, social workers and psychologists in dealing with the problems of children.

The clinics and staff conferences which have been held weekly for the past fifteen years have been used for the purpose of training students in social work, psychology and psychiatry. The Division of Mental Hygiene has co-operated with the Smith School for Psychiatric Social Work and with the School for Social Work at Simmons College, and anticipates working with the new School of Social Work connected with Boston College. Psychiatrists from time to time have also received short periods of training at the clinics. These men, to a very large extent, have been recruited from our own state hospitals. The clinics are always available for such training. We have no record of the actual number of men and women who have availed themselves of the opportunity of working at the clinics, but they have come from Monson, Danvers, Taunton, Westborough and Northampton.

Although the clinics were organized and developed primarily as therapeutic centers, we have not lost sight of the value of the accumulation of clinical data for research purposes. There is appended a list of the papers which have been written and published by the Division of Mental Hygiene dealing with the various phases of child psychology, family relationships and mental hygiene.

Keeping in mind the importance of educating the public, the Division of Mental Hygiene has had a very close working plan with the Massachusetts Society for Mental Hygiene. These two organizations have participated in no small amount of educational work during the past fifteen years, — education in the sense that throughout the State many parents, teachers, nurses, doctors and social agencies have been awakened to the need of recognizing early symptoms of maladjustment in children which lead to delinquency and mental instability in later life, and to seek assistance from the sources available throughout the State which are operated by both public and private organizations. In other words, the Massachusetts Society for Mental Hygiene with the Division has attempted to educate the public with reference to the needs for the type of clinic which the Division of Mental Hygiene, with the co-operation of the state hospitals, has been organizing. This educational work has been done very largely through lectures, radio and the printed word, stressing the importance of mental health as a factor in the individual's happiness and efficiency, and attempting to provide facilities for the protection of mental health comparable to those the public enjoys for the protection of physical health.

The pamphlets and monographs prepared by the Division of Mental Hygiene, including "Child Management" and "Guiding the Adolescent," have had considerable educational value. "Child Management" was published by the Children's Bureau in Washington, and over a million copies have been distributed. A series of pamphlets relating to personality deviations and undesirable habits in children was published by the National Committee for Mental Hygiene, and had an extremely wide distribution and are still being used in various clinics throughout the country. These particular pamphlets were reprinted in several different languages for the purpose of making them more valuable to the foreign elements coming to the clinics. One might add in passing that the clinics have received visitors from practically every part of the world.

This recognition is mentioned, as it perhaps bears some evidence of the value placed upon what the State of Massachusetts has done in the field of mental hygiene.

A survey of the laboratory activities for the past fifteen years would be extremely difficult to present in any concise form, but a carefully prepared bibliography is appended of the researches, authors and place of publication of work that has been done by or in co-operation with the Division of Mental Hygiene since it was first organized. These researches have been directed to a very large extent by Dr. Abraham Myerson at the Boston State Hospital, Dr. Harry C. Solomon at the Boston Psychopathic Hospital, Dr. Roy Hoskins at the Worcester State Hospital, and the Director of the Division with, as will be noted, numerous collaborators.

In an effort to create more interest in research problems throughout the state hospitals, and to aid and stimulate those who might have contributions to make in the field of research, Dr. Overholser, in May, 1935, appointed a Department Research Committee made up of Drs. Myerson, Thom, Hoskins, Dayton and Solomon. This committee was selected for the purpose of stimulating and co-ordinating research in the various institutions under the Department of Mental Diseases, feeling that a group of workers interested in various aspects of research would be in a position to contribute more generously to the needs of the individual hospitals and the schools which came under the supervision of the Department. To each member of the Research Committee was assigned a group of hospitals which he was to investigate as to the research work being pursued, the facilities for such work, and what members of the staff, if any, were prepared to assume research responsibilities. The committee has given the matter of research considerable attention, held several meetings, received protocols outlining certain types of research from various members of the hospital staffs, and has co-operated with these individual members in an attempt to promote research activities.

One of the functions of the Research Committee was to guide and direct those members of the state hospital staffs who were interested in research and urge them to take up a specific problem, either clinical, statistical or from the laboratory, and to pursue it in such a careful, critical manner that our knowledge about mental illness would be enhanced because of these efforts. There are many young people on the hospital staffs who have a desire to do something more than the routine

hospital duties, but who are unfamiliar with the techniques and disciplines of research, and who are not oriented as to what has been done in a particular field of research, or even how to obtain the information that is available with reference to the particular subject in which they are interested. The research activities of the entire state hospital services might well be given a great impetus in the right direction if this Research Committee were enlarged so as to include outstanding physicians, physiologists and chemists who are working in other fields of medicine. This topic is to be considered in more detail in the report of the subcommittee organized to make a study of the Department of Mental Diseases.

The objectives for which the Division of Mental Hygiene has been working have been outlined in a very general way, and there is appended a record of the activities of the laboratory researches and clinical activities under the organization. The report of the subcommittee already mentioned should cover in more detail how best a Division of Research can serve the needs of the State. Inasmuch as this report is to be in the hands of your committee in the near future, it is only mentioned in passing.

Appended to this general statement is —

1. A list of researches.
2. A list of clinics conducted by the state hospitals and the Division of Mental Hygiene, with a separate list of those clinics which have been organized by the Division of Mental Hygiene and the supervision which they have at the present time.
3. A list of appropriations and expenditures of the Division of Mental Hygiene since it was started in 1922. This table also indicates the amount of money which has been expended by the dementia praecox researches and the child guidance clinic at the Worcester State Hospital.

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LIST OF PUBLICATIONS FROM THE DIVISION OF PSYCHIATRIC RESEARCH,
1925-37, BOSTON STATE HOSPITAL.

Group I. Chemistry of the Brain.

A group of studies on the pressure and the chemistry of the brain was carried out for several years, the basis of the study being a jugular puncture, by which it became possible to study blood directly coming from the brain, in so far as its chemistry and pressure were concerned. This technique is now quite widely used as a means of studying brain activity, and has been utilized notably by the Boston City Hospital Research Division in studies on circulation of the brain and epilepsy.

This series of publications directly demonstrated those factors which influence the pressure within the brain as well as showed that the brain is an active metabolic organ using up sugar and oxygen in very definite amounts, and indicated the conditions under which

this use of sugar was increased and decreased. To illustrate this point, the pressures within the head were found to be markedly changed by drugs and by posture. Further, the effect of insulin, a chemical substance largely used in treatment of various conditions, and lately introduced into the treatment of general paresis, has been shown to be associated with a marked change in the use of oxygen by the brain; that is to say, if a large dose of insulin is given, the brain uses much less oxygen than previously, and may be thrown into a serious condition, due to what amounts to asphyxiation.

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Group II. Human Autonomic Pharmacology.

In this series of studies the effects of chemical substances which operate very much as does one part of the nervous system, the autonomic nervous system, have been extensively studied on the various organs of the body. As an immediate practical result, it may be stated that the influence of benzedrine sulfate on the mood of man has been definitely established, and it has been found that in certain conditions a very beneficial effect is produced by this drug, whereas in other conditions no effect, or even harmful effects, may be had. Moreover, the X-ray study of the gastrointestinal tract has been definitely helped by use of this drug, in that it tends to relieve spasm of the intestine in a very marked measure. A great deal of light has been thrown on the physiology of the body as related to the activity of autonomic drugs by these publications, and it may be stated that the exhibit of the laboratory was one of the few to receive honorable mention at the last American Medical Association convention.

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Group III. Mineral Studies and Pathology.

The rôle of the minerals in the functioning of the organism has become of increasing importance, just as the rôle of the vitamins has become highly significant. This laboratory utilized two new methods, — the microincineration method and the spectroscopic studies. These are highly technical procedures, involve a great deal of careful work, and certain fundamental papers on the subject have emanated from this laboratory. The first comprehensive study done on the minerals of the brain has come from this laboratory. It has been shown, for example, that young cells contain more minerals, and the older tissues of the body, including the brain, become deficient in minerals. In other words, one of the processes by which youth and old age are differentiated has come clearly to light. Furthermore, all actively growing tissues, such as tumors of various kinds, show an increased mineral activity. Perhaps more pertinently, as recently discovered by this laboratory, certain types of feeble-mindedness, hitherto of unknown physiology, are definitely associated in certain groups by differential mineral metabolism, and in other groups by an increased mineral activity.

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ALEXANDER, L., and MYERSON, A.: Minerals in Normal and Pathologic Brain Tissue, Studied by Microincineration and Spectroscopy. *Arch. Neurol. and Psychiat.* To be published.

ALEXANDER, L., and CAMPBELL, A. C. P.: Local Anaphylactic Lesions of the Brain in Guinea Pigs. *Am. J. Path.* 13, 2: 229-248 (March), 1937.

CAMPBELL, A. C. P.; ALEXANDER, L.; and PUTNAM, T. J.: The Vascular Pattern in Various Lesions of the Human Central Nervous System. Studies with the Benzidine Stain. *Arch. Neurol. and Psychiat.* To be published.

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- MYERSON, A.; LEARY, T.; and HODGSON, J. S.: Symposium — Intracranial Pathology, Lesions, Diagnosis and Treatment. *New England J. Med.* 204, 984-992 (May 7), 1931.

Group IV. Eugenics and Sterilization Studies.

This group of studies was done by the Director and his associate, Dr. Leo Alexander, as the chairman and research associate, respectively, of a committee appointed by the American Neurological Association. This work has thrown clear light on the limitations of any sterilization techniques in relationship to the present knowledge concerning mental disease and feeble-mindedness. This work definitely excludes epilepsy from the hereditary list of the diseases. Moreover, it demolishes many false assumptions made in the literature, and, on the whole, tends to establish in a clear and more precise manner the relationship of heredity to the mental diseases. This work has been officially endorsed by the American Neurological Association and by the American Eugenics Society.

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- MYERSON, A.: Summary of the Report of the American Neurological Association Committee for the Investigation of Sterilization. *Am. J. Psychiat.* 92, 3: 615-625 (Nov.), 1935.
- MYERSON, A. (Chairman): Eugenical Sterilization — A Reorientation of the Problem, by the Committee of the American Neurological Association for the Investigation of Sterilization. *The Mac-Millan Co.*, New York, Oct., 1936, pp. 211.

Group V. The Neuroses.

In this series of papers the Director has attempted to make clear the various developments of the symptom groups constituting the

neuroses, and to bring them into line with physiology as well as psychology. It cannot, of course, be stated that any direct practical results have followed, except so far as a clearer and more precise definition of a problem is the first essential to desired results.

MYERSON, A.: The Physiological Approach to the Psychoneurosis. Bulletin of the Massachusetts Department of Mental Diseases, 15, 1 and 2 (April), 1931.

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Group VI. Other Studies.

These include by-products of the various activities of the laboratory, have received attention in the literature, and are part of the general progress of medicine.

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DAMESHEK, W.: The White Blood Cells in General Paresis. Bulletin of the Massachusetts Department of Mental Diseases, 15, 1 and 2 (April), 1931.

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DAMESHEK, W.: Primary Hypochromic Anemia (Hypoferrism). Ill. West Va. Medical J. 30, 5 (May), 1934.

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It must be stated in relationship to all research that what one laboratory does becomes the starting point for the activities of another laboratory. There is a collaboration in science which is of vital importance. The work of this laboratory, it can be stated without undue modesty, has become firmly incorporated into the working technique of medicine at the present time. Most of the problems of psychiatry are still unsolved. This laboratory's work is in direct line to their solution. That solution may not come for a generation or two, but this is a short time in science, and especially in those extraordinarily difficult problems which relate to the mind of man.

LIST OF PUBLICATIONS FROM THE DEPARTMENT OF THERAPEUTIC RESEARCH, BOSTON PSYCHOPATHIC HOSPITAL.

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MEMORANDUM REGARDING THE NEURO-ENDOCRINE RESEARCHES AT THE WORCESTER STATE HOSPITAL.

The first endeavors at Worcester centered around endocrine studies, involving the extensive use of various endocrine therapies. In 1931 we turned, in addition, to a study of the "natural history" of schizophrenia; that is, we began studying the variation of a large number of physiological and psychological functions in schizophrenic patients and in normal controls. These orientation studies lasted through 1934.

An analysis of the accumulated data revealed certain facts which may be regarded as leads for researches on schizophrenia. The data point: (a) towards a depressed and otherwise anomalous oxygen metabolism, (b) an impairment of the autonomic nervous system, and (c) towards difficulties of integration on the physiological as well as on the psychological level.

Since 1935 our activities have, in the main, assumed an "experimental" character, largely determined by the above three leads. At present this experimental activity is being organized more systematically around central concepts and around the exploitation of the possibilities which insulin administration offers as a tool of exploration.

In addition to funds from the Commonwealth, the research project at Worcester is at present in receipt of an annual subvention from the Rockefeller Foundation in the amount of \$16,500, and from the Memorial Foundation for Neuro-Endocrine Research of approximately \$20,000. Substantial aid from various pharmaceutical firms in the form of valuable medications is also received.

The money from the Memorial Foundation for Neuro-Endocrine Research, the Rockefeller Foundation, and the Armour Fund is spent independent of the Department of Mental Diseases, but the Department is called upon to approve the maintenance of a certain number of research workers. As a matter of fact, this maintenance is a substantial contribution on the part of the State.

In addition to the following publications we have several in press and in preparation:

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ROBINSON, L. J.: Benzedrine Sulfate in the Treatment of Syncope Due to a Hyperactive Carotid Sinus Reflex. *N. E. J. M.* To be published in 1937.

ROBINSON, L. J.: Syncope, Convulsions and the Unconscious State: Their Relationship to the Hyperirritable Carotid Sinus Reflex Amongst 1,000 Patients in an Institution for Epilepsy.

ROBINSON, L. J.: Notes on the Observed Effects of Prostigmin.

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Research in progress at the present time:

Gastrointestinal Studies by X-ray Examination of Patients with Epilepsy.

Blood Calcium and Phosphorus Studies in Patients with Epilepsy.

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RAEDER, O. J., and CANAVAN, MYRTELLE M.: Remarks on the Pathology of the Feeble-Minded. *Bulletin of the Massachusetts Department of Mental Diseases*, XIV, Nos. 1-2, p. 234, April, 1930.

RAEDER, O. J.: Interim Report on the Third Series of Ten Cases (Waverley Researches in the Pathology of Feeble-minded), presented before the Boston Society of Psychiatry and Neurology on March 18, 1926. Report of these proceedings and discussions published in *Arch. of Neurol. and Psychiat.*, Vol. 16, p. 505, 1926.

CLINICS CONDUCTED BY STATE HOSPITALS AND DIVISION OF MENTAL HYGIENE.

Attleboro. — Taunton State Hospital, Mental and Mental Hygiene Clinic, Sturdy Memorial Hospital. Last Mon. 1.30-4 P.M.

Belchertown. — Belchertown State School General Out-Patient Clinic at the institution. Wed. 9-11 A.M., 1-4 P.M.

Belmont. — Grafton State Hospital Adjustment Clinic, Junior High School Building. 1st and 3d Mon. 9.30 A.M.—3.30 P.M.¹

Beverly. — Danvers State Hospital Habit Clinic, Health Center. Wed. 9–11 A.M.¹

Boston. — Boston Psychopathic Hospital Out-Patient Department. Daily, 2–5 P.M. (for children), and 9–12 A.M. (for children and adults).

Boston Dispensary Habit Clinic. Wed. and Thurs. 9.30 (Division of Mental Hygiene).¹

New England Hospital Habit Clinic. Thurs. 9.30 (Division of Mental Hygiene).¹

West End Habit Clinic, 25 Blossom Street. Wed. 2 P.M. (Division of Mental Hygiene).¹

Foxborough State Hospital Mental Hygiene Clinic, Boston Psychopathic Hospital. Last Mon. 7 P.M.

Westborough State Hospital Clinics, Massachusetts Memorial Hospital. Tues. 10 A.M.—4 P.M. (General Out-Patient); Wed. 10 A.M.—4 P.M. (Mental and Mental Hygiene).

Brockton. — Foxborough State Hospital Mental and Mental Hygiene Clinic, Brockton Hospital. Wed. 2–4 P.M.

Concord. — Grafton State Hospital Adjustment Clinic, High School. 1st and 3d Wed. 9.30 A.M.—3.30 P.M.¹

Fall River. — Taunton State Hospital Mental and Mental Hygiene Clinic, City Hall Annex. Wed. 9.30–12 A.M.

Fitchburg. — Gardner State Hospital Child Guidance Clinic. Mon., Fri. 1.30–4 P.M.¹

Gardner State Hospital General Out-Patient Clinic, City Hall. Wed. 3–5 P.M.

Gardner. — Gardner State Hospital Child Guidance Clinic, Prospect Street School. Tues. 1.30–4 P.M.¹

Greenfield. — Northampton State Hospital Mental and Mental Hygiene Clinic, Franklin County Hospital. 3d Tues. 1–3 P.M.

Haverhill. — Danvers State Hospital Child Guidance Clinic, High School. Sat. 9–11 A.M.¹

Holyoke. — Northampton State Hospital Child Guidance Clinic, Skinner Clinic of Holyoke Hospital. Wed. 1–3.30 P.M.¹

Lawrence. — Danvers State Hospital Mental and Mental Hygiene Clinic, International Institute. 1st and 3d Fri. 9–11 A.M.

Lawrence Habit Clinic, General Hospital. Tues. 2 P.M. (Division of Mental Hygiene).¹

Leominster. — Grafton State Hospital Adjustment Clinic, Junior High School. Fri. 9.30 A.M.—3.30 P.M.¹

Lexington. — Grafton State Hospital Adjustment Clinic, High School. Tues. 9.30 A.M.—3.30 P.M.¹

¹ For children only.

- Lowell.* — Lowell Habit Clinic, General Hospital. Wed. 2 P.M. (Division of Mental Hygiene).¹
- Westborough State Hospital* General Out-Patient Clinic, St. John's Hospital. 1st Tues. 7 P.M.
- Lynn.* — Danvers State Hospital Child Guidance Clinic, Child Welfare House. Tues. 9-11 A.M.¹
- Danvers State Hospital Mental and Mental Hygiene Clinic, Lynn Hospital, Wed. 2-4 P.M.
- Melrose.* — Danvers State Hospital Child Guidance Clinic. Thurs. 9.30-11.30 A.M.¹
- Natick.* — Grafton State Hospital Adjustment Clinic, High School. 1st and 3d Thurs. 9.30 A.M.-3.30 P.M.¹
- New Bedford.* — Taunton State Hospital Mental and Mental Hygiene Clinic, Olympia Building. Wed. 1.30-4 P.M.
- Newburyport.* — Danvers State Hospital Child Guidance Clinic, Health Center. 2d and 4th Fri. 2-4 P.M.¹
- North Adams.* — Northampton State Hospital Mental and Mental Hygiene Clinic, Board of Health Rooms. 2d Thurs. 1-3 P.M.
- Northampton.* — Northampton State Hospital Child Guidance Clinic, People's Institute. Wed. 4-6 P.M.¹
- Northampton State Hospital General Out-Patient Clinic at the institution. Daily 9.30-11 A.M., 1.30-4.30 P.M.
- North Grafton.* — (1) Grafton State Hospital Adjustment Clinic. Sat. 9-12 A.M.¹
- (2) Grafton State Hospital General Out-Patient Clinic at the institution. Sat. 9-12 A.M.; other days, by appointment.
- North Reading.* — North Reading Sanatorium Habit Clinic. 1st Tues. 10 A.M. (Division of Mental Hygiene).¹
- Norwood.* — (1) Habit Clinic, Norwood Hospital. Fri. 9.30 (Division of Mental Hygiene).¹
- (2) Medfield State Hospital Child Guidance Clinic, Norwood Hospital. 3d Tues. 3-5 P.M.¹
- Orange.* — Gardner State Hospital Child Guidance Clinic, Visiting Nurses' Rooms. 1st Wed. 1.30-4 P.M.¹
- Pittsfield.* — Northampton State Hospital Mental and Mental Hygiene Clinic, House of Mercy Hospital. 4th Thurs. 1-3 P.M.
- Quincy.* — Habit Clinic, Woodward Institute. Thurs. 2.30 P.M. (Division of Mental Hygiene).¹
- Medfield State Hospital Child Guidance Clinic, High School. Thurs. 2-4 P.M.¹
- Medfield State Hospital Juvenile Court Clinic, District Court. Tues., except the third, 2-4 P.M.¹
- Reading.* — Habit Clinic, High School. Tues. 2 P.M. (Division of Mental Hygiene).¹

¹ For children only.

Salem. — Danvers State Hospital Child Guidance Clinic, Pinkham Memorial Hospital. Mon. 2-4 P.M.¹

Springfield. — Northampton State Hospital Juvenile Court Clinic, District Court. Fri. 9 A.M.¹

Northampton State Hospital Mental and Mental Hygiene Clinic, Board of Health Rooms. 1st Thurs. 2-4 P.M.

Springfield Hospital Child Guidance Clinic (State auspices in part. Morgan B. Hodskins, M.D., loaned by Monson State Hospital). Mon., Wed. 2-5 P.M.; Fri. 2-4 P.M.¹

Taunton. — Taunton State Hospital Mental and Mental Hygiene Clinic at the institution. Thurs. 10-12 A.M.

Waltham. — Westborough State Hospital General Out-Patient Clinic, Department of Public Welfare, City Hall. 2d Tues. and 3d Wed. 7 P.M.

Waverley. — W. E. Fernald State School General Out-Patient Department at the institution. Wed. 9 A.M.

Westborough. — Westborough State Hospital General Out-Patient Clinic at the institution. Daily, except Sat. and Sun., 2-5 P.M.; 1st Sun. 3 P.M.

Worcester. — Worcester Child Guidance Clinic — Daily, full time.¹ (Sponsored by the Child Guidance Association in Worcester and by the Worcester State Hospital; is under state auspices.)

Wrentham. — Wrentham State School General Out-Patient Clinic at the institution. Wed. 8.30 A.M.

¹ For children only.

HABIT CLINICS.

List of Habit Clinics — Division of Mental Hygiene.

CLINIC.	Started.	Discontinued.	Remarks.
East Boston . . .	June 6, 1923	Oct. 2, 1924	Turned over to Boston Psychopathic Hospital.
North End . . .	June 8, 1923	July, 1928	Because it was considered more economical to transfer the cases to the West End clinic.
Roxbury Neighborhood House.	Oct. 25, 1923	Sept. 18, 1924	Because it was felt that the location of the clinic was not sufficiently accessible to serve the group for which it was intended, and the clinic was later moved to Boston Dispensary.
West End . . .	Jan. 12, 1924	- -	
Lynn . . .	Mar. 5, 1924	Mar. 30, 1926	Turned over to local auspices and later to Danvers State Hospital.
Lawrence . . .	Apr. 5, 1924	- -	
Boston Dispensary ¹ .	Dec. 5, 1924	- -	
Lowell . . .	Dec. 3, 1924	Nov. 30, 1927	
Lowell (reopened) .	Jan. 22, 1932	- -	
Reading . . .	Dec., 1924	- -	
Beverly . . .	Mar. 12, 1925	Apr. 13, 1932	Turned over to Danvers State Hospital.
Springfield . . .	Oct., 1924	Oct. 31, 1925	Turned over to Monson State Hospital.
Quincy . . .	Oct. 7, 1926	- -	
New England Hospital	Dec. 1, 1927	- -	
North End Consultant Clinic, North Bennet Street Play School.	Oct. 10, 1928	Oct., 1929	Because it was felt advisable to have all cases attend the West End clinic for more detailed study and treatment.
North Reading Sanatorium.	July, 1928	- -	
Norwood . . .	Oct. 11, 1929	- -	
Northampton . . .	May 15, 1931	Dec. 31, 1931	Turned over to Northampton State Hospital.
Holyoke . . .	June 12, 1931	Dec. 31, 1931	Turned over to Northampton State Hospital.

¹ Two clinics each week beginning March, 1933.

HABIT CLINICS — *Continued.**Increase in Number Treated — Division of Mental Hygiene.*

DATE.	Number of New Cases.	Total Cases Carried.	Visits of Children to Clinic.
Dec. 1, 1925-Dec. 1, 1926	368	-	1,275
Dec. 1, 1926-Dec. 1, 1927	355	471	1,474
Dec. 1, 1927-Dec. 1, 1928	418	481	1,570
Dec. 1, 1928-Dec. 1, 1929	509	600	2,264
Dec. 1, 1929-Dec. 1, 1930	498	628	2,523
Dec. 1, 1930-Dec. 1, 1931	603	708	2,411
Dec. 1, 1931-Dec. 1, 1932	594	800	2,857
Dec. 1, 1932-Dec. 1, 1933	795	1,091	3,565
Dec. 1, 1933-Dec. 1, 1934	681	1,053	3,492
Dec. 1, 1934-Dec. 1, 1935	643	1,035	3,317
Dec. 1, 1935-Dec. 1, 1936	666	1,042	3,759
Dec. 1, 1936-Dec. 1, 1937	724	1,136	4,185
Dec. 1, 1937-Dec. 1, 1938	760	1,150	4,652

HABIT CLINICS — *Concluded.**Appropriations and Expenditures — Division of Mental Hygiene.*

YEAR.	Appropriation.	Expenditures.	Worcester Child Guid- ance Clinic.	Dementia Præcox Research. ¹
1922	\$3,000 00	\$3,000 00 ²	—	—
1923	25,000 00	6,896 92	—	—
1924	25,169 98	18,598 53	—	—
1925	22,146 45	21,743 59	—	—
1926	23,562 86	18,541 20	—	—
1927	26,521 66	28,827 21	—	—
1928	27,500 00	26,203 41	—	—
1929	36,000 00	30,864 67	—	—
1930	83,150 00	66,660 17	\$9,153 97	\$16,088 99
1931	84,885 00	97,830 35 ³	14,920 20	26,137 09
1932	85,000 00	93,574 97 ⁴	13,499 00	24,657 77
1933	84,200 00	84,784 89 ⁵	12,257 23	22,020 40
1934	81,830 00	82,893 65 ⁶	11,178 60	22,460 63
1935	86,340 00	87,445 43 ⁷	13,084 54	25,105 27
1936	91,550 00	89,840 89 ⁸	12,674 98	24,376 73
1937	99,309 98	93,984 60	13,604 90	26,714 67
1938	110,220 00	97,386 89	13,387 78	27,982 07

¹ Included in column "Expenditures."² Established in 1922, and does not include balance brought forward from previous year.³ Balance brought forward from previous year, \$25,525.16.⁴ Balance brought forward from previous year, \$12,579.81.⁵ Balance brought forward from previous year, \$4,004.84.⁶ Balance brought forward from previous year, \$3,419.95.⁷ Balance brought forward from previous year, \$2,356.30.⁸ Balance brought forward from previous year, \$1,250.87.

MEMORIAL FOUNDATION FOR NEURO-ENDOCRINE RESEARCH —
WORCESTER RESEARCHES.

1933.

Salaries	\$19,021 08
Operating expenses	894 93
Total	\$19,916 01

1934.

Salaries	\$22,752 15
Operating expenses	1,652 20
Total	\$24,404 35

1935.

Salaries	\$20,068 16
Operating expenses	741 66
Total	\$20,809 82

1936.

Salaries	\$17,013 00
Operating expenses	948 98
Total	\$17,961 98

1937.¹

Salaries	\$9,343 27
Operating Expenses	805 80
Total	\$10,149 07

January, 1933, to June 30, 1937.

Salaries	\$88,197 66
Operating expenses	5,043 57
Total	\$93,241 23

¹ To June 30.

ROCKEFELLER FOUNDATION — WORCESTER RESEARCHES.

July 1, 1934, to June 30, 1935.

Receipts	\$16,500 00
Disbursements	16,360 60
	<hr/>
Balance	\$139 40

July 1, 1935, to June 30, 1936.

Receipts	\$16,360 60
Balance	139 40
	<hr/>
	\$16,500 00
Disbursements	16,291 62
	<hr/>
Balance	\$208 38

July 1, 1936, to June 30, 1937.

Receipts	\$16,291 62
Balance	208 38
	<hr/>
	\$16,500 00
Disbursements	15,403 29
	<hr/>
Balance	\$1,096 71

Total Actual Receipts, July 1, 1934, to June 30, 1937.

1934-35	\$16,500 00
1935-36	16,360 60
1936-37	16,291 62
	<hr/>
Total	\$49,152 22

Since July 1, 1934, a grant of \$16,500 per year, assured up to June 30, 1940.

From January, 1936, a grant of \$3,500 per year for 1936 and 1937, from Armour & Co.

From July 1, 1937, to June 30, 1940, a grant of \$49,500.

C. REPORT OF THE COMMITTEE ON RESEARCH CENTER AND METHODS TO THE SPECIAL COMMISSION.

Your Committee on Research Center and Methods submits the following considerations on research under the Department of Mental Diseases.

The State has a special responsibility with regard to mental disorders. It has more or less established a monopoly of the treatment of mental patients, and it is bound to accept all that is involved in the assumption of such responsibility. This responsibility is not met by the mere maintenance of a traditional level of care and treatment, but demands at the same time an intelligent, consistent and continuous program of research into the causes of insanity, and into the possible improvement of methods of study, treatment and care of mental patients. The steadily increasing demands made by mental disorders on the budget of the State makes research of the above nature obligatory and a matter of immediate concern.

The necessity for research is obvious in view of the many unsolved problems in the field of mental disorders. To deal with these problems requires a serious effort, intelligently directed and continuously maintained. It is not only the psychiatrist who is aware of the necessity for research. The intelligent taxpayer is becoming somewhat impatient under the increasing load of the budget for mental disorders which is chiefly expended in the direction of treatment and care of those who have already broken down. He anticipates increasing burdens with the growth of population, and he would like to see systematic research and a purposeful attack on the causes of insanity with a view to prevention, and on the treatment of insanity with a view to cure or amelioration.

The spirit of investigation and of inquiry should permeate every state hospital and be kept alive in every ward physician. The general clinical work in a hospital where no investigative work is being done is bound to fall to a level of dull mediocrity. Not only intellectual curiosity but the interests of the patients themselves make investigative work an essential aspect of the activity of a mental hospital. It is evident that every state hospital should have its own laboratory, not only as a center of investigation, but as a necessary condition of thorough study of the patients. The American Medical Association recognizes as accredited hospitals for the training of medical interns only

those hospitals which have an effective laboratory. At present it refuses to recognize as accredited hospitals several Massachusetts state hospitals.

It may be claimed that every ward physician in a mental hospital is responsible himself for maintaining an alert and active interest in investigation and for carrying on some individual piece of work however modest. It must be strongly emphasized that under the present arrangements, where ward physicians very often have an almost intolerable load of routine duties, the flame of interest in research is bound to flicker and finally be extinguished. Investigative activity cannot be carried on by men whose case-load is far beyond the standards set by the American Psychiatric Association, and completely uses up all the time and energies of the individual. It is important, in considering the development of investigative activity in the mental hospitals, to give due weight to the excessive demands that are already made on the ward physicians of many of these hospitals.

The investigative spirit in the individual ward physician is one of the most valuable assets of a mental hospital. It can be maintained only under favorable circumstances, with no chronic overburdening with daily routine, with adequate time for concentration on some personal topic of investigation, with a reasonable supply of medical journals and books available, and with opportunity for consultation and discussion with competent advisers. It is the responsibility of those in authority to establish and to maintain such favorable conditions.

The importance of research may be illustrated by the situation in industry. In many industrial organizations one finds large divisions fully manned and amply supplied with funds whose whole function it is to study certain fundamental processes which have a bearing on that industry. Many of these researches do not have an immediate utilitarian goal. The directors of these industries realize that research into fundamental processes, with fuller knowledge of the subtle underlying forces, will in the long run give them greater control over nature and enable them to deal more efficiently with their specific technical problems. It is true that some of these researches will bear upon the direct solution of some problem which is of immediate importance; other researches have a much longer range. Figures can be obtained to show that a considerable percentage of the annual expenditure in some large industries is devoted to research activities.

In general medicine the importance of research is clearly understood and generally accepted. In the field of the infectious and metabolic disorders noteworthy advances in public health have been made on the basis of the research activities of special workers. These results have been attained by the expenditure of large funds appropriated by Federal, state and municipal authorities, or made available by special foundations or by the endowments of medical schools and hospitals. For the study of a single disease like cancer large funds have been made available, and in many centers highly skilled workers are devoting all their energies to studying the basal factors underlying this disease.

In comparison with the funds available in industry and in the field of general medicine, the amount expended on research into mental disorders is negligible, although this is a field of health which has begun to arouse widespread interest and concern, and which has most important social implications.

It is well to recognize explicitly that the physical and chemical problems taken up for research in industry are of comparatively simple nature; the solution of a problem can often be at once turned to practical account, and may often bring in large financial gains directly dependent upon the solution of the problem. In general medicine the problems are more complicated than those of industry. But there, too, the results in the improvement of public health and the economic gains to the community are often easily demonstrable; the results of investigations in the field of infectious and metabolic disorders have often been capable of an immediate and practical application. It is well to realize that the field of mental disorders is somewhat different. With their complicated physiological, personal and social determinants one must expect research to be a more protracted affair, and one must not expect too rapid and easily demonstrable returns. Even when important causal factors are demonstrated, there may be greater resistance to innovations in view of the subtle influence of traditions and beliefs.

Responsibility for the prosecution of research into mental disorders devolves upon the State, which has taken under its care the great majority of mental patients. The effort put forth in research should be proportionate to the importance of the topic, and should not be looked upon merely as an incidental function or a side issue in the Department of Mental Diseases.

There is a tendency to consider mental disorders or mental diseases as if the term *disease* represented the same concept as when used in internal medicine. It is well, therefore, to keep in mind the concrete fact which the State has to deal with, — namely, mental patients or people who have broken down in a great variety of ways in their adaptation to the tasks of life. In each case one has to face the concrete fact of the human individual in his social environment, and one cannot start with the assumption that the key to the disorder has to be found by the exclusive investigation of biochemical or physiological processes. In a large proportion of cases the understanding and the treatment of the case require a consideration of problems of human adaptation involving psychological and sociological factors.

To make the situation with regard to research concrete, one may divide the general problems of research into those dealt with —

At the *impersonal* level (biochemical, physiological, immunological, etc.).

At the *psychological* level (analysis of the forces of the personality, — instincts, emotions, repressions, thwarting, privation, etc.).

At the *sociological* level (analysis of environmental factors in family, school, occupation, social group).

(a) *At the impersonal level* there are problems connected with —

The results of head injury.

The influence of poisons (alcohol, lead, etc.).

Vitamin deficiency of various types.

The composition of the blood and cerebrospinal fluid.

Disorders of various systems (the neuro-endocrine system, etc.), physiological and neurological symptoms, their nature and localization.

Puerperal disorders.

The psychiatric concomitants of bodily disorders.

The biochemical and physiological bases of the psychoses.

The methods involved in these studies are the methods of the basal medical sciences, — biochemical, physiological, pathological, immunological. They require special training, and, as a rule, special equipment and instruments of precision.

(b) *At the Psychological Level.* — In addition to the methods and principles of the basal disciplines referred to, the psychiatrist, to do justice to other factors in human nature, should

study the instinctive and emotional mechanisms, and investigate with increasing precision the dynamic equilibrium of the human personality and the adaptation of the human individual to the complex demands of his environment.

It is important to recognize that we still require detailed and systematic investigation into the natural history of mental disorders, their various types, their symptomatology, their evolution, their causes, their treatment.

Investigation is also required into such problems as follow:

The types of individual (constitutional traits) predisposed to special types of mental disorder.

Hereditary influences in mental disorders (the study of family psychoses, of identical twins).

The rôle of special traits in the evolution and in the equilibrium of the personality (sex constitution; power component; sensitiveness; phantasy; capacity for sublimation; social response; the result of conflicts, repressions, frustrations; the influence of special experiences; the development of compensations and special interests and codes).

The evaluation of psychoanalytic doctrines.

The analysis of special symptoms, *e.g.*, bed-wetting, morbid fears, sexual anomalies, wayward behavior, hallucinations, delusions, and of special syndromes, *e.g.*, the catatonic syndrome and its relation to similar syndromes in encephalitis and other conditions.

The methods of testing for special abilities and disabilities, the methods of testing the equipment of the individual ("intelligence," vocational, personality tests).

In this field of investigation the methods will not be merely those required for the investigation of the impersonal problems of the basic sciences, but will need to include the historical, the statistical, the psychoanalytic and other such methods.

(c) *At the Sociological Level.* — The relationship between the individual and his cultural environment is one of continual interaction; the isolated individual is an abstraction, a useful figment. The mental disorder can in many instances only be studied and treated adequately when due attention is paid to the situation in which the patient has evolved and to which he has to react.

Further research is required into —

The dynamic relationship between the individual child and the family setting, especially the parents.

The interaction between child and school setting (school-mates, teachers).

The relation of the individual to fellow workers and to occupational status.

The influence on the developing personality and on the adult of economic, racial, religious factors.

The influence of social resources or privations (*e.g.*, opportunities for cultural development, æsthetic satisfactions, recreation, social fellowship and group activities).

In such researches both the historical and the statistical method will be employed, with some use of the experimental method (*e.g.*, study of the same child in different foster homes, in relation to different teachers; modification in the industrial environment, etc.).

Research into the *causes and prevention of insanity*, as indicated by the above brief outline, may be especially focussed upon any one of the underlying topics:

Exogenous factors.

Genetic factors.

Constitutional vulnerability and its types.

Conditioning factors in the home, the school, the workshop, the neighborhood.

The rôle of economic, social and cultural factors; acute stresses.

Research into the *treatment of mental disorders* may be specially focussed upon special problems within the following fields:

Drugs, glandular products, physical procedures (hydrotherapy, fever therapy, etc.).

Psychotherapy.

Occupational therapy, social readaptation.

The comparative results of various types of care (*e.g.*, hospital, boarding-out, etc.).

The above outline indicates the variety of topics within the extensive and complex field of mental disorders which require further and prolonged investigation. Many of these topics are already being investigated, often by men seriously overburdened by their routine duties and heavy case-load.

Any comprehensive scheme for the investigation of all these topics would be Utopian. It is assumed by the committee that plans for the fostering of psychiatric research in Massachusetts will involve a certain continuity, and consist of development rather than any drastic rearrangement.

¶ The committee calls attention to the fact that special investigations are being carried on (a) at the Boston Psychopathic Hospital, which was established in 1912, with research into the causes and prevention of insanity as one of its special functions; (b) at the Boston State Hospital, where research is being carried on with the help of special funds from outside sources; (c) at the Worcester State Hospital, where there is a similar situation of external support for a special series of investigations; (d) at the State Department of Mental Diseases, where very important statistical researches have been made possible by grants from outside sources.

These grants from outside sources entitle one to hope that with honest support of research and solid guarantee of continuity the State may find its own efforts generously reinforced from other sources.

The Committee does not believe that Massachusetts needs any new central research building, nor does it recommend that there should be any bureaucratic control of research which would in any way hamper the best utilization by the individual worker of his native endowment and interests. It believes, however, that there should be quite explicit development of the function of research throughout the whole state hospital system, and that for this purpose there should be a definite division in the Department of Mental Diseases which has a special responsibility for this functional development. The director of this division should have a dignified status and a salary commensurate with his responsibility. The relations between the director of research, the central authority and the local authorities in the hospital would depend upon the organization of the Department and its personnel. The budget of the division should be reasonably proportionate to the scope of the work. The committee recommends that out of the total budget of the Department adequate funds should be allocated annually for the prosecution of the researches already on foot, and for those other important and promising researches which only await funds in order to be undertaken. The committee makes no recommendation of a specific annual figure in view of the various factors which are involved in the construction of the budget of the Department, and in view of the many and varying factors involved in the special research activities.

In this connection it seems relevant to call attention to the generous support which outside foundations have given to state departments, state hospitals and individual laboratories

when the foundations were convinced that an earnest and consistent endeavor was being made in the direction of an attack upon fundamental problems in an important health field. Such foundations do not wish in any way to relieve States or municipalities of their proper responsibilities, and are disinclined to be the sole support of investigations for which state and municipal authorities also have a certain responsibility. When they see, however, that a State is in earnest in doing its part in regard to such important health problems, they are often willing to give generous support over considerable periods of time. The committee wishes specially to emphasize this factor of the financial support of research which may be expected from various outside sources, such as the larger foundations when they are aware of the serious and continued interest of the State in psychiatric research. Individual workers are frequently in a position to bring the importance and the significance of special investigations to the attention of those who are able to give support to research. Funds from outside sources are particularly valuable, inasmuch as they give an elasticity to the organization of research activity which is not possible with the funds allocated by the state department.

As continuity no doubt is desired, the rôle of the head of the division of research will be not the institution of any new center, but rather the encouragement of the functional activity of the already existing centers, and the encouragement of research within the individual hospitals. It will be part of his function to assist in the establishment of an adequate laboratory in every state hospital, in the provision of facilities for encouraging the spirit of research in each state hospital, and in aiding the younger physicians to get appropriate further training in centers specially adapted to their needs and interest. It is recommended that he should have at his disposal a carefully chosen advisory committee on research composed of members representing the numerous and diverse fields of scientific activity which are closely related to the field of psychiatric research.

With regard to the individual hospitals, the committee recommends that steps be taken to establish a laboratory in each one of these hospitals, and that in his annual budget each superintendent should request a special appropriation for the specific investigation for which the members of his staff may require special funds and which they seem competent to carry on profitably.

APPENDIX 9.

PROBLEM OF MAINTENANCE.

A. INCOME.

The greatest source of income to the Department is now derived from the charge made to the relatives of patients for the board of such patients in the various institutions. The authority for such procedure is found in section 96, chapter 123 of the General Laws, which specifies that the Department may charge a sum not to exceed \$10 per week for each person who may be a patient in any of the hospitals except the Boston Psychopathic Hospital, where a limit is not established, and except in the State Infirmary and Bridgewater State Hospital, where no charge can be made for patients who are under sentence.

The appended table shows collections for the last ten-year period from the years 1929 to 1938, inclusive. It will be noted that in none of those years did the collections from this source go below three quarters of a million dollars. During the more progressive economic years the collections approximated \$1,000,000 per year, reaching a low point in 1934 and showing a gradual rise up to and including 1938. These collections have been made through the Division of Settlement and Support in the central department, which Division has six field workers or investigators.

The various investigators are notified by the hospitals as to newly admitted patients. They visit the hospitals, check the hospital records, talk with the patients, and then look into the various sources of income of the patients and legally responsible relatives. After this investigation an amount is established by the Department as to what is deemed an equitable weekly amount for the support of the patient.

The investigators are able to reach the hospitals at varying intervals of time; sometimes at two-week intervals, sometimes at monthly intervals. They thus contact patients and relatives many times after the situation which caused the patient's

admission to the hospital has become less acute, and thus the relatives in many instances resist a proposal for payment. Also, it should be noted that in view of the large number of patients who are admitted for short periods of time only (ten to thirty days) the investigators from the Department miss many opportunities for collection. Many patients are discharged before the investigators are able to get around to their regular visits. Likewise, in view of the high admission rate, together with the large backlog of the resident population in the hospitals, it is almost impossible for the investigators to keep up-to-date with any possible improved financial status of patients who have been cared for on a free or reduced cost basis.

The Commission has entertained seriously the thought that a separate investigator detached to the individual hospitals would be able to contact relatives at the time of admission of the patient, and would also be able to devote more time to rechecking the financial status of the resident population. We feel that the efforts of such investigators would probably return as income to the Commonwealth many times the cost of their services. It probably would not be feasible to carry out this suggestion in its broadest sense at the moment, but it might be tried in one or two strategic hospitals with high admission rates for a two-year period, and we so recommend.

The Commission has noted the large number of patients in our public hospitals who are citizens of this country but who do not have a settlement in the State. For many years the Department has followed the policy of removing these patients to the State of their legal settlement, and we encourage the continuance of this policy, particularly as it affects patients who are likely to require a long hospital residence. We have also had called to our attention certain patients whose income is such that they might well afford private hospital care. These patients should be encouraged to seek care in the properly licensed and less crowded mental hospitals. The Commission was surprised to learn that there were 4,538 aliens residing in the institutions on September 30, 1937, of whom 798 were admitted during that year. This represents a substantial percentage of the whole resident population of the hospitals. Based on the average cost of maintenance, Massachusetts' taxpayers are called upon to provide \$2,052,960 a year. The Department is cognizant of this group, and efforts

have been made in the past to deport these alien patients to their native countries, but the number has been relatively small. In view of the tremendous burden on Massachusetts' taxpayers, we strongly recommend that the Department immediately adopt an aggressive policy to return as many of these aliens as is possible. We further recommend that, through the Governor, it should seek the co-operation of the Federal government and the governments in other countries to relieve our citizens of this tax burden. The importance of this problem can be seen if one considers that if the entire alien patient population were removed, overcrowding in the hospitals would disappear, and the normal increase would be provided for several years to come.

The Commission has given special consideration to the suggestion that the statutory limit of \$10 per week for the support of patients be elevated to a higher figure. We believe that this may be worthy of further consideration at a later date, but we feel that the above suggestions aimed towards increasing collections under the present statutory limit should be carried out as a first step.

The Commission has taken cognizance of other sources of income derived from licenses issued to private hospitals, special receipts from sales, etc. The total amount of this income is relatively small, and we have no further recommendations to make regarding it.

Collections for Support of Patients, 1929-38, inclusive.

Year ending Nov. 30, 1929	\$939,846 19
Year ending Nov. 30, 1930	947,503 03
Year ending Nov. 30, 1931	917,593 67
Year ending Nov. 30, 1932	819,870 81
Year ending Nov. 30, 1933	778,830 53
Year ending Nov. 30, 1934	754,582 59
Year ending Nov. 30, 1935	779,117 76
Year ending Nov. 30, 1936	765,727 72
Year ending Nov. 30, 1937	769,417 17
Year ending Nov. 30, 1938	790,184 47
 Total	 \$8,262,673 94

B. EXPENSES.

The problem of maintenance expenses resolves itself primarily into the question of expenses for the institutions coming under the jurisdiction of the Department of Mental Health, since these institutions account for over 99 per cent of the total expenditures.

Table 1 shows the breakdown of these expenditures during the fiscal year ending November 30, 1938, and will give an idea as to the magnitude of the individual items entering into the expense problem:

TABLE 1. — *Total Expenditures, 1938, by Items.*

Personal services	\$6,497,947 59
Food	2,686,746 30
Medical and general care	285,922 18
Religious instruction	29,365 27
Farm	347,217 68
Heat and other plant operations	1,050,692 07
Travel, transportation and office expense	108,156 33
Garage and grounds	88,592 40
Clothing and materials	310,569 33
Furnishings and household supplies	411,191 12
Repairs, ordinary	208,565 80
Repairs and renewals	295,583 31
Total	\$12,320,549 38

Table 2 shows the breakdown of the per capita cost per week, based on patient population in each of the institutions. The Psychopathic Hospital is considered separately; the acute receiving hospitals (those who yearly admit 200 or more patients) are identified by (A) and are averaged as a group near the bottom of the table. The hospitals not receiving 200 acute admissions per year are identified as (B) and are likewise averaged near the bottom of the table. The three schools are considered separately and averaged; and an average is given for all institutions except the Boston Psychopathic Hospital.

This table is self-explanatory except the last column, which gives a factor indicating the equivalent of 1 cent per patient per week. These figures are simply for the matter of convenience. They are not absolutely accurate, but they do approxi-

mate accuracy. By using these figures one can readily translate any item in the subdivisions of the table into total costs; for example, under the caption "Clothing and Materials" it is indicated that the Medfield State Hospital spent per patient per week, 21.3 cents. The 1 cent expenditure factor in the last column referring to Medfield is \$947.42. Multiplying these two figures together gives a total of \$20,180.04 expended for the entire year. The detailed reports show that the Medfield State Hospital actually spent \$20,150.33. Again, the factors may be used properly in studying total costs, even though they only approximate accuracy. These same factors may be used in the other tables to follow in arriving at an estimate of total costs.

Table 3 shows a similar breakdown, but involving the one item "Personal Services," and it shows the various subdivisions into which each such institutional services are classified.

Table 4 shows the same breakdown in relation to "Medical and General Care;" Table 5, in regard to "Clothing and Materials;" Table 6, in regard to "Furnishings and Household Supplies."

A study of these total cost figures is, of course, only a part of the entire picture which is built around the policy of providing for the patients in the institutions adequate medical care, good food, reasonable clothing, personal services within reasonable limits; and, likewise, working, recreational and devotional accommodations within rational limits and with relative freedom from hazards.

TABLE 2. — *Total Expenses, 1938.*

[Per capita costs per week, based on patient population, expressed in dollars.]

INSTITUTION.	Personal Service.	Food.	Medical and General Care.	Religious Instruction.	Farm.	Heat, etc.	Travel, etc.	Garage and Grounds.	Clothing and Materials.	Furnishings and Household Supplies.	Repairs, Ordinary.	Repairs and Renewals.	Total.	Expenditure of 1 Cent per Capita per Week, equivalent to —
<i>Hospitals.</i>														
Psychopathic	\$39.688	\$5.993	\$3.079	\$0.266	-	\$2.813	\$1.102	\$0.150	\$0.170	\$0.833	\$0.631	\$1.077	\$55.807	\$45.09
Boston State (A)	5.197	2.022	.197	.016	\$0.009	.834	.082	.070	.287	.322	.252	.244	9.537	1,231.13
Danvers (A)	4.131	1.771	.139	.017	.253	.894	.074	.050	.226	.323	.177	.144	8.204	1,197.56
Foxborough (A)	4.506	1.851	.160	.018	.272	.704	.083	.053	.205	.317	.127	.159	8.461	736.23
Medfield (A)	4.535	2.017	.155	.022	.272	.584	.064	.046	.213	.284	.117	.147	8.454	947.42
Northampton (A)	3.964	1.837	.200	.013	.197	.699	.050	.044	.157	.283	.132	.157	7.733	1,057.41
Taunton (A)	4.515	1.922	.132	.024	.278	.671	.081	.033	.146	.287	.141	.154	8.385	884.78
Westborough (A)	4.726	1.836	.174	.018	.260	.680	.078	.099	.224	.266	.143	.201	8.706	833.97
Worcester (A)	5.080	2.039	.350	.023	.196	.709	.067	.053	.188	.304	.131	.258	9.430	1,221.40
Gardner (B)	4.338	1.961	.500	.017	.423	.789	.066	.097	.230	.244	.178	.377	9.222	743.54
Grafton (B)	5.030	1.909	.189	.021	.394	.835	.067	.081	.256	.300	.147	.287	9.517	801.55
Metropolitan (B)	3.979	1.754	.190	.021	.038	.855	.059	.054	.221	.271	.083	.227	7.752	971.77
Monson (B)	4.944	1.868	.127	.019	.227	.891	.078	.065	.203	.299	.145	.170	9.036	808.61

TABLE 2. — *Total Expenses, 1938 — Concluded.*

[Per capita costs per week, based on patient population, expressed in dollars.]

Institution	Personal Service.	Food.	Medical and General Care.	Religious Instruction.	Farm. etc.	Travel, etc.	Garage and Grounds.	Clothing and Materials.	Furnishings and Household Supplies.	Repairs, Ordinary.	Repairs and Renewals.	Total.	Expenditure of 1 Cent per Capita per Week, equivalent to —
Sub-total averages:													
Psychopathic	\$39.688	\$5.993	\$3.079	\$0.266	—	\$2.813	\$0.150	\$0.170	\$0.833	\$0.631	\$1.077	\$55.807	\$45.09
Group (A)	4.599	1.918	.194	.019	\$0.208	.732	.056	.208	.300	.157	.187	8.654	8,109.93
Group (B)	4.546	1.865	.244	.020	.256	.843	.073	.227	.279	.135	.261	8.817	3,325.49
Sub-total averages, Groups (A) and (B).	4.584	1.902	.209	.019	.222	.764	.061	.214	.294	.150	.209	8.702	11,435.43
Schools.													
Belchertown	4.297	1.970	.158	.023	.401	.580	.083	.246	.279	.144	.102	8.460	678.13
Fernald	4.117	1.670	.116	.027	.304	.729	.066	.246	.269	.111	.229	7.952	1,020.24
Wrentham	3.537	1.743	.104	.017	.343	.482	.055	.227	.242	.123	.153	7.088	1,034.50
Sub-total averages	3.942	1.772	.122	.022	.343	.598	.067	.239	.261	.124	.191	7.750	2,732.87
Grand total averages	4.572	1.890	.201	.021	.244	.739	.082	.219	.289	.147	.208	8.669	14,213.40

Method of Computation.

Northampton, religious instruction expenditure, 1.3 cents \times \$1,057.41 = \$1,374.63 (actually spent, \$1,400).
 Medfield, clothing expenditure, 21.3 cents \times \$947.42 = \$20,180.04 (actually spent, \$20,150.33).
 Westborough, total expenditure, 870.6 cents \times \$833.97 = \$726,054.28 (actually spent, \$726,094.94).

TABLE 3. — *Personal Services, 1938.*

[Weekly per capita costs, expressed in dollars.]

Institution.	Medi- cal.	Admin- istra- tion.	Kitchen and Dining Room.	Domes- tic Service.	WARD SERVICE.		Indus- try and Educa- tion.	En- gineering Depart- ment.	Repairs.	Farm.	Stable, Garage and Grounds.	Total.	Expendi- ture of 1 Cent per Patient per Week, equiva- lent to --
					Male.	Female.							
Hospitals.													
Psychopathic	\$8.805	\$10.776	\$2.290	\$2.598	\$5.389	\$5.332	\$0.560	\$2.990	\$0.935	-	-	\$39.683	\$45.09
Boston State (A) . . . . .	.313	.453	.333	.421	1.240	1.560	.149	.282	.220	\$0.082	\$0.145	5.198	1,231.13
Danvers (A) . . . . .	.316	.311	.267	.239	.998	1.124	.072	.337	.199	.199	.067	4.131	1,197.56
Foxborough (A) . . . . .	.370	.397	.320	.327	.978	1.125	.086	.360	.186	.225	.130	4.506	736.23
Medfield (A) . . . . .	.276	.302	.277	.315	.958	1.290	.101	.392	.244	.268	.111	4.535	947.42
Northampton (A) . . . . .	.323	.281	.261	.266	.892	1.120	.060	.280	.196	.209	.076	3.963	1,057.41
Taunton (A) . . . . .	.350	.366	.337	.256	1.110	1.089	.083	.403	.229	.210	.082	4.515	884.78
Westborough (A) . . . . .	.365	.383	.407	.373	.979	1.082	.070	.517	.206	.281	.062	4.726	833.97
Worcester (A) . . . . .	.321	.432	.314	.442	1.221	1.365	.096	.353	.201	.193	.118	5.080	1,221.40
Gardner (B) . . . . .	.346	.385	.461	.199	1.124	.867	.138	.261	.202	.253	.103	4.338	743.54
Grafton (B) . . . . .	.378	.336	.428	.411	1.067	1.083	.101	.444	.281	.353	.149	5.030	801.55
Metropolitan (B) . . . . .	.277	.308	.307	.237	1.057	1.121	.063	.256	.173	.090	.090	3.979	971.77
Monson (B) . . . . .	.341	.310	.372	.266	1.270	1.355	.075	.329	.258	.280	.088	4.944	808.61

TABLE 3. — *Personal Services, 1938 — Concluded.*

[Weekly per capita costs, expressed in dollars.]

INSTITUTION.	Medi- cal.	Admin- istra- tion.	Kitchen and Dining Room.	Domes- tic Service.	WARD SERVICE.		Indus- try and Educa- tion.	Fin- gineering Depart- ment.	Repairs.	Farm.	Stable, Garage and Grounds.	Total.	Expendi- ture of 1 Cent per Patient per Week, equiva- lent to —
					Male.	Female.							
Sub-total averages:													
Psychopathic	\$8.805	\$10.776	\$2.290	\$2.598	\$5.389	\$5.332	\$0.569	\$2.990	\$0.935	-	-	\$39.683	\$45.09
Group (A) . . . .	.326	.367	.312	.333	1.059	1.240	.092	.358	.210	\$0.202	\$0.100	4.599	8,109.93
Group (B) . . . .	.332	.332	.386	.277	1.126	1.112	.092	.320	.226	.236	.107	4.546	3,325.49
Sub-total averages, Groups (A) and (B).	.328	.357	.333	.317	1.078	1.203	.092	.347	.215	.212	.102	4.584	11,435.43
<i>Schools.</i>													
Belchertown . . . .	.326	.408	.240	.142	.761	1.110	.309	.398	.248	.243	.110	4.207	678.13
Fernald . . . .	.286	.359	.252	.135	1.195	.847	.328	.275	.169	.204	.067	4.117	1,020.34
Wrentham . . . .	.274	.337	.151	.102	.856	.917	.256	.299	.129	.152	.063	3.537	1,034.50
Sub-total averages . . . .	.292	.363	.211	.124	.959	.939	.296	.315	.174	.194	.076	3.942	2,732.87
Grand total averages . . . .	.348	.391	.316	.287	1.069	1.165	.132	.349	.209	.208	.096	4.572	14,213.40

TABLE 4. — *Medical and General Care, 1938* — Concluded.

[Weekly per capita costs, expressed in cents.]

Institution.	Expenditure of 1 Cent per Patient per Week, equivalent to —															
	Books.	Entertainment.	Funeral.	Gratuity.	Labor.	Manual Training Supplies.	Medicines.	Medical Attention (Extra).	Patients Boarded Out.	Return of Runaways.	School Books.	Sputum Cups.	Tobacco Pipes.	Toilet Articles.	T. B.	Total.
Sub-total averages:																
Psychopathic	30.05	.77	-	-	21.03	2.16	80.36	-	-	-	-	-	.36	4.07	-	307.83
Group (A) . . . . .	.88	1.00	.41	.10	1.14	.01	7.78	1.88	3.14	.005	.01	.007	1.75	1.36	.001	19.44
Group (B) . . . . .	.89	.92	.65	.002	1.16	.01	6.55	1.37	9.50	.004	.02	.01	2.14	1.01	-	24.29
Sub-total averages, Groups (A) and (B) . . . . .	.88	.98	.48	.07	1.15	.01	7.42	1.73	4.99	.005	.01	.009	1.86	1.25	.0008	20.85
<i>Schools.</i>																
Belchertown	2.26	.94	.14	-	.38	.25	5.55	1.21	2.50	.03	.80	-	.03	1.59	.03	15.76
Fernald	1.75	.85	.10	-	.81	.68	3.49	2.02	-	.02	.29	-	.05	1.47	-	11.58
Wrentham	1.56	.56	.09	-	1.28	.09	3.33	1.08	-	.009	.95	-	.15	1.29	-	10.43
Sub-total averages	1.81	.75	.11	-	.88	.35	3.94	1.46	.62	.02	.66	-	.09	1.43	.008	12.18
Grand total averages	1.15	.94	.41	.06	1.16	.08	6.98	1.67	4.14	.008	.14	.007	1.52	1.30	.002	20.09
																14,213.40

NOTE. — \$290.80 subtracted from total of Metropolitan State Hospital (refund account of reimbursing patient); \$7,626.31 included in total of "Psychopathic" (laundry done outside) = 53 cents in grand total.

TABLE 5. — *Clothing and Materials, 1938.*

[Weekly per capita costs, expressed in cents.]

INSTITUTION.	Boots, Shoes, etc.	Outer Clothing.	Under Clothing.	Dry Goods for Clothing.	Hats and Caps.	Leather, etc.	Machinery for Manu- facturing.	Socks and Smallwares.	Total.
<i>Hospitals.</i>									
Psychoopathic	2.56	4.56	6.70	2.04	.08	.01	—	1.11	17.06
Boston State (A)	5.91	9.43	9.12	1.63	.53	.14	.09	1.90	28.75
Danvers (A) . . . . .	.31	6.48	3.76	7.00	.26	2.28	.24	2.34	22.67
Foxborough (A)	2.65	5.30	4.91	4.95	.08	.25	.21	2.20	20.55
Medfield (A)	3.46	3.08	1.66	9.77	.48	.27	.25	2.28	21.26
Northampton (A)	3.20	4.44	3.29	2.77	.13	.34	.01	1.47	15.66
Taunton (A) . . . . .	.50	.73	1.22	8.28	.26	1.92	.16	1.56	14.64
Westborough (A)	2.92	6.55	4.84	5.68	.10	.33	.01	1.96	22.39
Worcester (A)	3.46	4.58	3.30	5.04	.18	.52	.14	1.58	18.81
Gardner (B)	1.39	1.74	.25	12.99	.17	4.65	.50	1.29	22.99
Grafton (B)	4.08	10.17	2.43	5.68	.40	.55	.44	1.88	25.63
Metropolitan (B)	3.53	9.54	3.12	3.64	.27	.49	.14	1.38	22.11
Monson (B)	2.44	9.29	2.60	3.31	.10	1.00	.28	1.31	20.34

TABLE 5. — *Clothing and Materials, 1938 — Concluded.*

[Weekly per capita costs, expressed in cents.]

INSTITUTION.	Boots, Shoes, etc.	Outer Clothing.	Under Clothing.	Dry Goods for Clothing.	Hats and Caps.	Leather, etc.	Machinery for Manu- facturing.	Socks and Smallwares.	Total.
Sub-total averages:									
Psychopathic	2.56	4.56	6.70	2.04	.08	.01	—	1.11	17.06
Group (A)	2.88	5.25	4.14	5.48	.27	.78	.14	1.90	20.84
Group (B)	2.92	7.89	2.19	6.14	.24	1.56	.33	1.46	22.72
Sub-total averages, Groups (A) and (B)	2.89	6.02	3.57	5.67	.26	1.01	.19	1.77	21.39
<i>Schools.</i>									
Belchertown	3.12	4.05	1.88	11.39	.20	2.25	.60	1.09	24.59
Fernald	8.68	6.61	1.44	4.63	.20	1.27	.40	1.35	24.59
Wrentham	5.65	3.50	2.23	7.29	.16	1.52	.01	2.33	22.70
Sub-total averages	6.15	4.80	1.85	7.31	.18	1.61	.30	1.66	23.87
Grand total averages	3.52	5.78	3.25	5.98	.24	1.12	.21	1.75	21.85

TABLE 6. — *Furniture and Household Supplies, 1938.*

[Weekly per capita costs, expressed in cents.]

Institution.	Beds, Bedding.	Carpets, Rugs.	Crockery, etc.	Dry Goods, etc.	Electric Lamps.	Fire Hose.	Furniture and Up- holstery.	Kitchen.	Laundry.	Lavatory.	Machinery for Manufacturing.	Table Linens, etc.	Furnishing Super- intendent's Apartment.	Total.	Expenditure of 1 Cent per Patient per Week equiv- alent to —
Hospitals.															
Psychoopathic	18 00	3 70	9 53	.03	.16	.84	13 12	17 05	1 37	8 03	-	5 99	5 53	83 35	45 09
Boston State (A)	10 29	.01	3 50	.35	.01	.13	4 21	7 17	2 60	2 45	.02	1 38	.07	32 20	1,231.13
Danvers (A)	15 32	.07	3 13	1 15	.88	.07	.81	5 34	2 25	1 01	.02	2 02	.25	32 34	1,197 56
Foxborough (A)	9 89	.12	2 69	.46	.84	.07	1 90	7 56	3 24	1 17	-	3 71	.10	31 74	736 23
Medfield (A)	9 69	.21	2 20	.31	.73	.19	1 10	6 30	3 36	1 01	.16	3 02	.11	28 39	947 42
Northampton (A)	9 42	1 91	.90	.51	.54	.19	.97	8 37	2 79	1 05	.08	1 54	.04	28 31	1,057 41
Taunton (A)	5 75	.90	4 13	.47	1 01	.28	2 16	7 32	3 11	1 30	.08	1 89	.28	28 69	884 78
Westborough (A)	11 32	.11	1 52	.31	.93	.27	.39	5 44	2 39	1 19	.04	2 63	-	26 55	833 97
Worcester (A)	7 74	1 10	3 29	.32	1 74	.33	2 77	6 40	2 58	1 34	.17	2 55	.09	30 42	1,221 40
Gardner (B)	4 87	.21	1 73	.71	.68	.18	2 95	7 50	2 07	.88	.30	2 34	-	24 42	743 54
Grafton (B)	10 45	.61	2 17	.31	1 03	.43	1 38	8 89	2 40	.80	-	1 58	-	30 03	801 55
Metropolitan (B)	5 19	.32	3 82	.50	.44	.11	2 17	8 38	3 47	.73	-	1 82	.12	27 08	971 77
Monson (B)	10 51	.93	2 02	.71	.39	1 03	2 51	6 70	1 54	2 01	-	1 18	.35	29 88	808 61

TABLE 6. — *Furniture and Household Supplies, 1938 — Concluded.*

[Weekly per capita costs, expressed in cents.]

INSTITUTION.	Expenditure of 1 Cent per Patient per Week equivalent to —														
	Beds, Bedding.	Carpets, Rugs.	Crockery, etc.	Dry Goods, etc.	Electric Lamps.	Fire Hose.	Furniture and Upholstery.	Kitchen.	Laundry.	Lavatory.	Machinery — for Manufacturing.	Table Linens, etc.	Furnishing Superintendents' Apartments.	Total.	Expenditure of 1 Cent per Patient per Week equivalent to —
Sub-total averages:															
Psychopathic	18.00	3.70	9.53	.03	.16	.84	13.12	17.05	1.37	8.03	—	5.99	5.53	83.35	45.09
Group (A)	10.04	.57	2.71	.50	.83	.19	1.88	6.71	2.75	1.35	.07	2.26	.12	30.00	8,109.93
Group (B)	7.68	.51	2.52	.55	.62	.43	2.24	7.90	2.43	1.09	.07	1.72	.12	27.87	3,325.49
Sub-total averages, Groups (A) and (B)	9.35	.55	2.66	.52	.77	.26	1.98	7.06	2.66	1.28	.07	2.10	.12	29.38	11,435.43
<i>Schools</i>															
Belchertown	3.88	.82	3.09	.64	.53	.35	3.06	9.14	3.80	1.10	.02	1.47	—	27.92	678.13
Fernald	7.03	.66	1.61	.15	.33	.33	2.73	8.28	3.20	.58	.56	1.18	.28	26.90	1,020.24
Wrentham	7.92	.39	1.37	.41	—	.12	2.08	6.46	2.75	.81	.08	1.67	.18	24.25	1,034.50
Sub-total averages	6.59	.60	1.89	.37	.25	.23	2.56	7.80	3.18	.80	.25	1.44	.17	26.14	2,732.87
Grand total averages	8.85	.57	2.53	.49	.67	.26	2.13	7.23	2.75	1.20	.11	1.99	.14	28.93	14,213.40

I. PERSONAL SERVICES.

This problem constituted an expense item of approximately \$6,500,000 in 1938.

This item is of such magnitude that a special section has been devoted to discussing it, and it is referred to many times in discussions, both in the body of this report and the various appendices. In view of this it would be redundant to go into the detail of personal services at this point. We would again call attention, however, to the fact that the institutions are not overmanned, and that in certain instances service could undoubtedly be improved by the addition of new or rearrangement of present personnel. The Department for several months has been engaged in a resurvey of the entire personnel problem.

It was our feeling that this was purely an administrative matter and one which we as a Commission should leave to the Department for further consideration. However, in checking over budgetary items, including transfers between items in a five-year period, we learned that occasionally there have been transfers from the personal services item to other items. For example, money was transferred from the personal services item for the purpose of buying farm machinery. We do not, in view of the constant clamor for additional personnel, believe this is a good practice. When the Legislature appropriates money for personal services, such sums should be used only for that purpose. On the other hand, to prohibit such transfers by legislation would be harmful rather than helpful, as the personal services item is a flexible one and would be most quickly available if an emergency arose. We understand this departmental policy applies also to transfers from the food item. We are pleased, therefore, that the Department has adopted a policy of refusing to approve transfers from the personal services item unless a grave emergency can be shown.

The personnel item is an ever-increasing expense. This is due in some measure to the constant increase of patients in the institutions which, of course, requires additional personnel. It is likewise due to the annual step-rate increases which the state service offers to employees for faithful and long service.

II. Food.

This item constitutes the second largest one from the standpoint of maintenance costs. In 1938 it approximated a cost of \$2,700,000.

Food is unquestionably one of the most vexing problems with which the institutions are faced. It is a problem which is of intense interest, not only to the patients and employees in the institutions, but also to those persons who have relatives or friends in the institutions and to the public at large.

In our report last year we referred somewhat to this problem and commented that patients in the institutions were adequately fed. We did point out, however, that there was something radically wrong with the methods of computing appropriations for food, and it is this latter point that we will dwell upon here.

For a period of many years the Department figured the food budgetary requests on a basis of a ration which undoubtedly was originally established on a firm foundation, but it had not undergone thorough study and revision for many years, and it was somewhat outdated. From our investigations, practically all of the superintendents felt that there should be radical revision and a ration set-up as it applied to eggs, fruit, milk, butter and sugar. It likewise felt that the ration had not taken into consideration as much as it should of various groups of patients involved, such as youthful, invalid, overactive, hard-working and disturbed patients. There also were many complaints because the ration was set up on the basis of patients only and appropriations made on that basis. Food for the employees and officers of the institution had to be taken from this amount. This did not seem to be an equitable basis, either for figuring a balanced ration or for figuring appropriation needs.

The above problems have been given considerable study, and the Department co-operating with the recommendations of the Commission has adopted a new method of figuring.

Food for a given year is obtained from several sources. It is either (1) purchased within that year, (2) home produced within that year, (3) taken out of inventory of food left over from the previous year, or (4) given to the institution. The latter point is quite irregular and can be disposed of rapidly by stating that from time to time it has been possible to obtain small amounts of certain food items from the Surplus Commodities Division of the Federal government under the restrictions governing such commodities. These gifts are not reflected materially in total costs for food.

Food is dispensed to patients and employees (the latter consist of regular employees, special employees and students)

and also to certain officers of the institutions who are permitted a yearly dollar and cent allowance.

By referring to Table 7, it will be easy to follow the use of these factors in computing 1938 budget requests for purchased food.

Column 1. Merely enumerates the various institutions.

Column 10. The revised ration was estimated to cost approximately 24.3 cents per individual per day in those institutions where food was procured for a large number of people (the Boston Psychopathic Hospital being the only exception).

Column 9. Shows the same figure on a yearly basis.

Column 8. Details the quota of patients and employees who actually eat in the hospital dining rooms and who represent the total so-called "feeders" at the institution.

Column 7. Is arrived at by multiplying the figures of Columns 8 and 9, and shows the total amount estimated necessary for food for those who eat in the institution dining rooms.

Column 6. Indicates the allowance for the family maintenance of certain institutional officers who are entitled to such allowance. This amount is obviously not available for the use of patients or the general run of employees who eat in the usual dining room.

Column 5. Is arrived at by adding Columns 6 and 7 together, which indicates the total food allowance for every one at the institution.

Column 4. Indicates the food inventory available at the various institutions at the close of the fiscal year of 1937.

Column 3. Indicates the estimated value of food that would be produced at the institution during 1938.

Column 2. Indicates the final budget request for food, which funds had to be appropriated in 1938. It is arrived at by subtracting the figures in Columns 3 and 4 from the total food allowance necessary, which is found in Column 5.

From this table it will be seen that all institutions, except the Boston Psychopathic Hospital, were put on essentially the same equitable basis, allowing the internal administration of each hospital to make ration allowance adjustments for the variations found necessary in the different groups of patients.

It was not thought that this standardized ration and cost would necessarily be a panacea for all the food problems. It was started simply as a basis for equitable feeding and management control, with the idea of revision downward as further study would indicate might be proper.

TABLE 7. — Analysis, 1938 Food Budget Recommendations.

1	2	3	4	5	6	7	8			9	10
Institution.	Budget Recommendations.	Estimated Home Produce.	Actual Storehouse Inventory, Nov. 30, 1937.	Total Food Allowance.	Allowance for Family Maintenance for Officers.	Total Amount to Institution "Feeders."	ESTIMATED NUMBER OF "FEEDERS"—EMPLOYEES PLUS PATIENTS.			Allowance per Year per Person.	Allowance per Day per Person.
							Em- ployees.	Patients.	Total.		
Hospitals.											
Psychopathic	\$28,000	-	\$1,506	\$29,506	\$700	\$28,806	117	90	207	\$139.10	\$0.381
Boston State	247,800	-	16,298	264,098	2,576	261,492	591	2,330	2,921	89.50	.245
Danvers	144,200	\$80,670	13,018	237,888	4,170	233,718	369	2,260	2,629	88.75	.243
Foxborough	88,200	44,300	10,168	142,668	3,361	139,307	214	1,340	1,554	89.50	.245
Gardner	74,500	67,560	20,104	162,164	5,370	156,794	314	1,450	1,764	88.75	.243
Grafton	93,800	62,420	13,354	169,574	4,233	165,341	327	1,535	1,862	88.75	.243
Medfield	132,600	59,516	12,489	204,605	2,978	201,627	377	1,890	2,267	88.75	.243
Metropolitan	167,800	8,000	12,619	187,419	4,207	184,212	249	1,810	2,059	89.50	.245
Northampton	136,200	62,364	13,098	211,662	3,945	207,717	369	1,970	2,339	88.75	.243
Taunton	118,400	53,030	17,973	190,003	3,763	186,240	400	1,686	2,086	89.00	.244
Westborough	114,300	55,929	9,622	179,851	5,005	174,846	404	1,560	1,964	89.00	.244
Worcester	202,000	55,700	6,177	263,877	6,451	257,426	570	2,330	2,900	88.75	.243
Monson	117,000	41,310	9,966	168,276	3,976	164,300	321	1,530	1,851	88.75	.243
Schools.											
Belchertown	75,400	55,996	13,134	144,530	3,761	140,769	242	1,320	1,562	90.00	.2465
W. E. Fernald	120,900	77,050	12,982	210,932	3,489	207,443	433	1,900	2,333	89.00	.244
Wrentham	115,600	67,000	20,256	202,856	4,727	198,129	321	1,910	2,231	88.80	.2435

Of particular concern in the figures brought to light last year was the general high value of food inventories. One of the goals in the food problem was aimed at diminishing the higher inventories.

Table 8, detailing the 1939 food requests, shows some of the revisions obtained from a year of close study. It is demonstrated in certain minor variations and the allowance per person per day, and in the marked diminution of inventory.

Our investigations show that the Department is continuing to study the whole problem of food from a point where it is received after having been raised or purchased by the institution through its storage, preparation, service, consumption and waste. To that end, a commissary agent was added to the Department for the sole purpose of studying the entire food problem and carrying out such experimentations as would be necessary and reducing it to a simpler and more equitable form.

The Commission believes that the Department and its co-operating institutions have done a very creditable piece of work during the past year in regard to this tremendous problem, and believe that it will ultimately result in better service at proportionately lower cost.

III. MEDICAL AND GENERAL CARE.

This item is represented by a total expenditure in 1938 of approximately \$286,000.

Table 4 details the breakdown of the individual hospital expenses in this item for 1938. It will be noted that there is a wide variation in costs in certain of these items, and it is hoped that this will be a subject for scrutiny by the Department. It is satisfying to note that in the budget for the biennium 1939 to 1940 the Department has made some attempt to standardize costs for certain general types of care within reasonable limits.

The cost of family care or boarding out of patients is expressed in this particular division of expenditures. This particular subject has been a point of discussion in other sections of this report. It is hoped that this program will be continued and will become an integral part of the administration of each institution.

Generally speaking, the hospitals are fairly well equipped for the carrying out of the usual medical and surgical pro-

TABLE 8. — *Estimated Analysis, 1939 Food Expenditures.*

1	INSTITUTION.	2	3	4	5	6	7	8			9	10
								ESTIMATED NUMBER OF "FEEDERS"—EMPLOYEES PLUS PATIENTS				

cedures. A few hospitals have lagged behind and we suggest that they be encouraged to modernize their facilities in this regard.

A large item of cost is that allocated to toilet and personal articles. Over a period of years the institutions have encouraged their patients to increase their self-respect through increased personal appearance and personal hygiene. This is an excellent policy, and it is reflected to a degree in this division of the appropriation.

In like manner, entertainment and tobacco have contributed materially to the enjoyment and general good mental hygiene of the patients and are expressed in this item.

We suggest that careful study be given to any program which would call for curtailment of the present standards of medical and general care. A new division of hospital inspection within the Department will undoubtedly be particularly concerned with this latter point.

IV. RELIGIOUS INSTRUCTION.

This item amounted to an annual expenditure of approximately \$30,000 in 1938.

It provides for the spiritual welfare of the patients and embraces the Protestant, Catholic and Jewish faiths. All institutions have access to ministration from recognized representatives of these three denominations.

V. FARM.

This item amounted to an expenditure of approximately \$347,000 in 1938.

Farms are run in connection with the institutions for the purposes of (1) producing home-grown food and (2) serving as an outlet, in the way of occupational therapy, for patients. The various farm activities seem to provide an excellent therapeutic outlet for large numbers of patients in the schools for mental defectives. However, the superintendents are of varied opinions as to the therapeutic value of certain farming activities to adult psychotic patients. Certain superintendents feel that vegetable gardens which require varied activity and in which the season is relatively short are therapeutically worth while. They express the opinion, however, that when patients are assigned to the more permanent routine duties connected with the care of cattle and swine, they are liable to be overlooked at a time when they might leave the hospital.

Since the main value of the farm seems to be concerned with the value of food produced, it would seem worth while to continue the special study started by the Department last year in correlating the value of production with costs, and minimizing farm activities where they appear too costly. To this end it is worthy to note that the Department has recently abandoned the farm at the Boston State Hospital. At the close of the last fiscal year it eliminated the raising of swine at the Foxborough State Hospital, and has concentrated the collection of garbage from the Metropolitan Boston hospitals to be delivered to the Danvers State Hospital, where it is used for raising pork at a relatively cheap price.

These appear to be commendable steps and show the result of co-ordinated effort between the Department and the institutions. The Department maintains a farm co-ordinator, who is the immediate director of this activity.

We suggest that this form of study be continued to other aspects of farm activity, bearing in mind that the expense of personal services at the farm is an integral part of farm costs.

VI. HEAT AND OTHER PLANT OPERATIONS.

The items making up this division of expense have to do with the heating of the buildings, gas, electricity, water for the entire institution, refrigeration and sewage disposal. In 1938 these operations represented a total cost of approximately \$1,000,000.

Variations in cost are dependent largely upon condition in hospitals from year to year. The Department engineers in conjunction with those at the institutions, those in other state departments, and certain private engineering firms, over a period of years have made many studies relating to the problems reflected in this item of cost. Studies have had to do with the relative merits of steam or water for heat; technical aspects of high cost boiler and generating units; relative merit of oil and coal for fuel; the merit of gas, coal or electricity for cooking purposes and the relative value of manufactured *versus* purchased electricity; and the merits of water, sewage and electric rates, etc. These represent technical problems of such financial magnitude that all possible advice should be sought with the single goal in mind of providing necessary care to the patients at the lowest possible cost.

We commend the co-operation shown between the institutions and Department engineers and the inter-relationship of

the engineers of the Departments of Mental Health, Public Safety, Public Health, Public Utilities, and the Commission on Administration and Finance.

VII. TRAVEL, TRANSPORTATION AND OFFICE EXPENSE.

This portion of the cost of maintenance represented \$108,000 in 1938.

The items making up this cost are individually small. They constitute postage, telephone, travel costs, etc., and the control of them must, of necessity, be distributed in so many hands that it should require eternal vigilance on the part of both the Department and the hospitals to minimize these costs.

There is a limit below which, if costs are cut, inefficiency in service is bound to result. During the past year the Department gave some study to telephone costs and installed a teletype between the Department and two strategically placed hospitals, — Worcester State Hospital and Monson State Hospital. An analysis of these costs over previous telephone costs has not been completed.

It is probable that as the program goes forward for additional family care for patients, there may be an increase in travel expenses necessitated by increased demands for community supervision of these patients.

We recommend that further study be given to the cost of these various items which, of necessity, are so flexible.

VIII. GARAGE AND GROUNDS.

The total cost of these items in 1938 approximated \$89,000.

The variations in cost from year to year are accounted for mainly by the turnover of passenger cars and trucks, with the occasional addition of one of these items as necessity demands.

We feel that further study should be given to the question of repairs to motor vehicles, and also to the costs involved in the purchase of implements, tools and materials used for work on the roads and grounds.

IX. CLOTHING AND MATERIAL.

The items making up this division approximated a cost of \$311,000 in 1938. Clothing is obtained from several sources during a given year: (1) purchased; (2) manufactured at the institution; (3) supplied by relatives and friends of patients;

and (4) withdrawn from inventory which is accumulated from the previous year.

A great deal of ready-made clothing which is purchased must by statute and regulation be purchased from the Department of Correction. This has been a subject of controversy over a long period of time, and one regarding which many of the superintendents have strong opinions. There is much to be said on both sides. The superintendents complain that the quality and workmanship of the clothing supplied to the institutions by the Department of Correction is below standard of clothing which they could purchase outside. On the other hand, the Department of Correction argues that the superintendents put in orders and demand delivery within a ridiculously short time.

Further, the correctional authorities state that there has been a marked increase in the workmanship of the clothing manufactured by their Department, with the installation of more modern machinery and equipment. In any event, hard feelings and bickering between two state departments do no good to any one. We believe that through the co-ordinative efforts between the two departments and the Commission on Administration and Finance, mutual satisfaction will be gained, to the ultimate benefit of the patients.

We have been told that if a system of annual production is installed, savings to the taxpayers will be enormous. In the hospitals at all times there is a certain minimum number of patients. The needs of these patients, the Commission believes, can be accurately gauged well in advance of actual needs. By installing a system of annual production, the Department of Correction could group orders for certain clothing and buy the materials in larger quantities at a lower cost. With the advent of biennial budgets, the installation of this annual production can be made much more easily.

Clothing manufactured at the institutions is readily discernible through a study of the costs enumerated in Table 5; for example, in those institutions where the per capita cost for boots and shoes is low, the cost of leather for manufacturing them within the institution is relatively high, such as is represented in the case of Danvers and Taunton State Hospitals. It will be noted, also, that at Gardner and Monson State Hospitals there is a considerable manufacture of shoes, but the cost for purchased boots and shoes is also high, and this refers primarily to items which are used by patients out of

doors in winter, which items are not manufactured. The same point applies to Taunton State Hospital in the cost for outer clothing which is low and the relatively high cost of dry goods for manufacturing clothing. It is also well shown in the Gardner State Hospital, with a low cost for purchased underclothing but a correspondingly high cost for dry goods for manufacturing clothing. The manufacture of clothing in the institutions gives an outlet for some industrial therapy to patients, but not all superintendents are united in their opinion as to the value of such therapeutic outlet.

Prior to the onset of the general economic depression, large amounts of clothing were received from the friends and relatives of patients. This has decreased materially in recent years. One or two of the hospitals, however, through the personal diligent efforts of the administration, have succeeded in maintaining a fairly good level of home-furnished clothing. In one hospital, approximately 50 per cent of the clothing needs of the women patients is furnished by family and friends. Particularly should such gifts be welcome during the various holiday seasons. We are led to believe that the therapeutic advantages are great to the patients who receive clothing from their own home or friends. This tends to minimize the stigma, if any, that may be attached to the wearing of state clothing.

We urge the continued efforts of those hospitals which have shown good results in maintaining the level of home-furnished clothing, and the renewed strong efforts of those hospitals which have fallen behind in recent years. It seems to us that this is one place where therapeutic advantages to the patients can be rendered at lower cost to the Commonwealth, and we cannot stress too much the urgency of further efforts to procure clothing from home.

The expenditures for clothing over the years have varied tremendously in the institutions. It is apparent to the Commission that no uniform amount per patient per year for clothing will ever completely answer the requirements in each and every institution. However, we do believe that as a basis from which to work, an attempt at some degree of standardization should be tried. It would seem to us that a large proportion of the general clothing should be in use among the patients, and that there should be relatively little inventory except for seasonal clothing. A study of clothing inventory might be worth while. It is pleasing to note that in the final budgetary requests for the biennium 1939-40, the Department

has attempted to establish a standard minimum allowance for this trial period, taking into consideration the three sources from which clothing is obtained. As might be expected, a slightly higher standard was established for the schools than for the hospitals. This procedure is similar to that which was followed in the case of food. We understand that the Department is continuing further studies in regard to this problem, and that the studies should result in material savings in years to come. We approve of and encourage these studies.

X. FURNISHINGS AND HOUSEHOLD SUPPLIES.

This division of expenses approximated \$411,000 in 1938. The items making up this division are of such a nature that their only appreciable sources for a given year are through purchase or withdrawals from inventory, and they are so varied that administrative control is spread out into the hands of many individuals. A rapid survey of the items making up this division, found in Table 6, will greatly illustrate this point. Again, the majority of these items are of such a nature that they can well be standardized, and some effort at standardization of individual items has been made over a period of many years. Considerable study as to breakage of such items as crockery, and a study of loss of smallwares, such as electric light bulbs, crockery, silverware, table linen, etc., would indeed be worth while with a view to better management control. Many of the items making up this cost are of such a nature that, if storage facilities are available and control is proper, they might be purchased at a time and in sufficient quantities to take advantage of downward market fluctuations. These are all points for further detailed study, and we understand that the Department has already embarked upon such a program.

As in the case of clothing, the Commission is not convinced that standardization will solve all of the problems concerned in this division of expense, but we do believe that an attempt at some degree of standardization should be tried as a basis from which control and management could be increased to the ultimate benefit of the Commonwealth. It is to be expected that a lower standard basis might be established for the schools than would be the case in the hospitals. The Department in its requests for the biennium, 1939-40, has made a beginning in this regard, following the same general principles that were involved in the requests for food and clothing. Further steps

would undoubtedly depend upon the results of this two-year trial period.

What we have had to say regarding the installation of an annual production system in the case of clothing applies also to the manufacturing of furnishings and household supplies.

XI. REPAIRS, ORDINARY.

The items making up this division constituted an expense of approximately \$209,000 in 1938. They constitute lumber, paint, brick, hardware, cement, electrical supplies, steam and plumbing supplies, tools, and the many other items which are so necessary in maintaining the physical upkeep of the institutions. It is obvious that the source of these items for any given year is mostly through purchase, but occasionally sizable inventories are accumulated. Because of the nature of these items, such an accumulation of surplus supplies is very easy to get out of administrative control. We discourage a tendency to such accumulations. We understand that the attention of the Department has been called to this, and it has taken steps to increase the control of these items and to redistribute to several institutions any large accumulation in a given institution. During the past year one hospital has made a decided attempt to place all of these items under strict control. We commend this action and look forward to a favorable report at the end of the trial year, — a report of such a nature that a similar system might be instituted in other hospitals.

Although we caution the overstocking of these supplies, we also point out the necessity of having adequate supplies on hand to maintain the buildings. The older buildings, engines, etc., need constant repair and upkeep in order to avoid premature heavy replacement expenses. The newer buildings likewise require a certain amount of upkeep and renovation. It is also true that failure of attention to repairs as they are needed not infrequently leads to larger expenses in other maintenance items. A small faucet leak, for example, if permitted to continue will be reflected in increased water cost.

Of special interest in the items making up this division of cost is that for paint. Repainting of wards and furniture is necessary periodically, and this forms an æsthetic appeal not only to the patients and employees in the institutions, but also to their visitors. It creates cheerfulness which is hard to

duplicate in any other way. The process of redecorating, particularly of articles of furniture, forms a good therapeutic outlet for large groups of patients in many institutions.

The whole question of repairs should, and undoubtedly will, receive further study as to relative costs in comparison with the needs of each institution. We are not prepared to state just how far standardization might go without hampering efficiency. It does seem to us, however, that there should be some balance between material purchased and the personnel available to use this material so as to minimize surplus. This particular point was given recognition by the Department in its final appropriation request for the biennium of 1939 to 1940.

XII. REPAIRS AND RENEWALS.

The total expenditure for this division approximated \$296,000 in 1938. It is made up of expense items which do not recur annually and which consist primarily of replacements of structures or machines which have outlived their usefulness from an efficiency point of view. The nature of these items is such that they cannot lend themselves to any general comment. Each one has to be considered on its merits and in relation to the individual institutions as circumstances arise. Since a repair and renewal project is based on urgent need for efficiency and economy, we suggest that, as appropriations become available for these projects, they be instituted with as little delay as possible.

APPENDIX 10.

STUDY OF THE LAWS.

A committee of superintendents was appointed by the Commission to study the laws relating to the Department of Mental Health and the hospitals under its jurisdiction. We have studied with a great deal of care the recommendations of the committee and have endorsed many of the changes suggested by them to assist them in their administrative duties. In addition, we have consulted others as to the effect of these laws and have studied many changes recommended to us by interested persons. Our recommendations for changes follow.

Through inadvertence the Department's authority to place at board any patient in a hospital which is in the charge of the Department was eliminated in the re-organization bill, and the authority to place patients at board was vested in the superintendent. That authority should be revived.

In addition, we believe that the amount which the Department or hospital may expend to place any such patient at board should be increased from \$4.50 to \$6. Our reason for so recommending is given in detail in section 14, on the problem of the psychotic adult, and referred to in several other sections. The proposed change is recommended in section 1.

Occasionally there are sentenced to the Massachusetts Training Schools boys and girls who, it is believed, should properly be at Bridgewater. Removal in a legal manner of these boys and girls to the department for defective delinquents at Bridgewater would be of considerable assistance to the training schools in solving a vexing administrative problem. We believe that in the best interests of the inmates in the training schools there should be some method whereby those who properly should be at Bridgewater can be transferred, and have so recommended in section 2 of the proposed act.

In our report we have given the reasons why we believe the Commissioner should have the advice and counsel of an Ad-

visory Council to the Department of Mental Health. We therefore recommend section 3.

Under section 43 of the present law the superintendent and assistant physician at Westborough State Hospital shall be of the homeopathic school of medicine. This seems to be an unnecessary restriction in these times, and it is recommended that this restriction be eliminated. We recommend, therefore, repeal of Section 43 of the present law in section 4 of the proposed act.

Section 5 protects the term of office of the superintendent and assistant physicians at the Westborough State Hospital.

Section 56 of the present law provides that in making a commitment of an insane person, the judge shall inquire of the applicant for his commitment whether he desires the insane person to be treated according to homeopathic principles of medicine. This, again, seems to us to be an unreasonable and unnecessary restriction at the present time, and in section 6 we have recommended its repeal.

Section 77 of the present law provides for a commitment of thirty-five days for observation purposes, and outlines the procedure to govern such a commitment. It further provides that a report shall be made to the judge within thirty days, and that the judge make final disposition within five days, or a total of thirty-five days from commitment to the time when a decision must be made. This five-day period allows very little opportunity for the judge to consider the case thoroughly and execute his final order, particularly in doubtful cases where additional information and medical evidence may be desired.

We do not believe it would impose a hardship on any one to increase this period to a total of forty days, and have so recommended in section 7.

The usefulness of section 66A of the present law, which authorizes commitment of feeble-minded persons to the Department with the approval of the Department, and establishes authority for the Department to transfer such patient to the school for the feeble-minded or cause his removal to the Department for Defective Delinquents at Bridgewater, would be greatly increased if provision were also included for the transfer of suitable patients to a school for the feeble-minded under the direct custody of the Department. We have proposed such a change in section 8.

Section 79 of the present law provides for emergency hospital care and treatment for a period of ten days for any one

needing immediate care and treatment because of mental derangement other than delirium tremens or drunkenness. Presumably, under ordinary circumstances a differentiation between drunkenness and mental disorder could be made. However, the differentiation of delirium tremens from delirium due to other causes would constitute a difficult diagnostic problem. In cases where there is an acute delirium there is obvious need for immediate care. Delirium from whatever cause may necessitate or justify immediate admission to a mental hospital, and any delay incidental to a differentiation of delirium tremens from other delirium might jeopardize life. To avoid possible hazard to life through delay incidental to differentiation, we recommend section 9.

The same problem of differentiation applies to those addicted to drugs. Under section 80 of the present law such persons "needing immediate care and treatment" can be admitted for a period not exceeding fifteen days. We have suggested a change so that any one appearing to need hospitalization can be admitted under section 10.

Section 82 of the present law prohibits detention in a jail, lock-up or place provided for the detention of criminals of any person suffering from "insanity, mental derangement, delirium or mental confusion except delirium tremens and drunkenness." A deletion of the restrictive implications of section 79 regarding delirium tremens has been recommended for favorable consideration. It is likewise recommended that this restriction be eliminated from this section. This will be accomplished by section 11 of the proposed act.

Section 86 of the present law authorizes voluntary admission of persons where such persons are competent to make an application. This authorization obviates necessity for delay and permits avoidance of embarrassment or resentment that might exist if court procedure were required.

As the section now stands there is an implied promise that no voluntary patient will be detained more than three days beyond his formal request for discharge. A patient detained on a voluntary basis should not be under the false impression that if his condition at the time of his request for release is such that he should not be allowed to go, it may be necessary to secure regular commitment; also it is believed that when the patient is in such mental condition as to be incapable of appreciating his true situation he should not be continued on a voluntary status, and authority should be given to permit

application for commitment after he has become incompetent. To correct this we recommend section 12 of the proposed act.

Section 87 of the present law authorizes voluntary admission of persons suffering from epilepsy, and requires that such patient shall not be detained for more than three months beyond the written notice of his intention or desire to leave the hospital. A study showed that the extended period of three months beyond given written notice seems to be unnecessary and impracticable. We recommend a reduction of the period from three months to ten days in section 13 of the proposed act.

Section 23 of the present law obligates the Department to apply for commitment to an institution in the case of insane, epileptic or feeble-minded persons who should be properly institutionalized but are resident in unlicensed places. The section, as at present worded, does not give the Department the authority to enter the place and examine the patient. In other words, the Department has no legal right, except by implication, to obtain the necessary information for any action under this section. It is therefore proposed that section 23 be amended as recommended in section 14.

Section 36 of the present law demands that the "superintendent or head physician of each institution, or in his absence one of the assistant physicians, shall *personally* keep under lock and key all implements or devices of restraint. . . ." The intent is apparently to afford a maximum safeguard against unwarranted use of restraint. It would seem, however, that sections 35, 37 and 38 of the present law afford ample protection against any indiscriminate use of restraint. These sections provide regulations for application of restraint, define restraint and specify the open records to be kept, and establish penalties for non-observance of these statutes. The obligation that a superintendent have personal custody over restraint devices seems unnecessary, and the proposed change is recommended in section 15 of the proposed act.

Section 40 of the present law requires that the buildings of each hospital shall have proper means of escape from fire, suitable apparatus for extinguishing fires, and that "no . . . building shall be erected or maintained . . . without a written certificate of approval from the building inspector of the department of public safety. . . ."

The care of mental patients requires that the majority of ward doors must be locked. The Department has often been

unable to comply with section 40 because locked ward doors are generally interpreted by building inspectors as "obstruction of egress," under the provisions of chapter 143. It seems unwise to suggest the repeal of section 40, inasmuch as adequate protection against fire and provisions for fire fighting must be maintained. We therefore recommend revision by means of section 16 of the proposed act.

PROPOSED LEGISLATION.

SECTION 1. Section sixteen of chapter one hundred and twenty-three of the General Laws, as amended by section nine of chapter four hundred and eighty-six of the acts of nineteen hundred and thirty-eight, is hereby further amended by striking out, in the eighth and ninth lines, the words "four dollars and fifty cents" and inserting in place thereof the words:—six dollars,— and by adding after the word "patient" at the end the following sentence:— The department shall have the same authority in the case of patients directly committed to it,— so as to read as follows:— *Section 16.* The superintendent of each state hospital may place at board in a suitable family or in a place in this commonwealth or elsewhere any patient in such hospital who is in the charge of the department and is quiet and not dangerous nor committed as a dipsomaniac or inebriate, nor addicted to the intemperate use of narcotics or stimulants. The cost to the commonwealth of the board of such patients supported at the public expense shall not exceed six dollars a week for each patient. The department shall have the same authority in the case of patients directly committed to it.

SECTION 2. Chapter one hundred and twenty of the General Laws is hereby amended by inserting after section seventeen, as appearing in the Tercentenary Edition, the following new section:— *Section 17A.* If any person committed or transferred to the industrial school for boys, to the Lyman school for boys, or to the industrial school for girls appears to the trustees to be mentally defective, they may remove such person to a department for defective delinquents established under sections one hundred and seventeen to one hundred and twenty-four, inclusive, of chapter one hundred and twenty-three for not more than forty days, but in no event beyond the expiration of his sentence, pending the determination of his mental condition. Within thirty days after such removal the medical

director appointed under section forty-eight of chapter one hundred and twenty-five shall report said person's mental condition to the said trustees.

If, in the opinion of said director, such person is not mentally defective, he shall so certify upon the order of removal, and notice, accompanied by a written statement regarding the mental condition of such person, shall be given to the said trustees, who shall thereupon cause such person to be reconveyed to the institution from which he was removed, there to remain pursuant to the original sentence.

If the said medical director certifies that such person is mentally defective the trustees shall forthwith recommend to the department of correction that such person be transferred to a department for defective delinquents, and the commissioner of correction shall immediately transfer such person to such a department, there to be held on the mittimus until the term of sentence expires.

Any person removed or transferred under this section shall be accompanied by all mittimuses and processes, a copy of the medical report, and a written statement covering the history and conduct of the person, and the circumstances of the person's home, so far as they can be ascertained.

At any time prior to the expiration of the term of sentence of such person, an officer of the department of correction, department of public welfare, or department of mental health may file in the court by which such person was committed an application for his commitment to a department of defective delinquents.

If, on a hearing on such application, the court finds the defendant to be mentally defective, and, after examination into his record, character and personality, that he has shown himself to be an habitual delinquent, or shows tendencies towards becoming such, and that such delinquency is or may become a menace to the public, and that he is not a proper subject for the schools for the feeble-minded or for commitment as an insane person, the court shall make and record a finding to the effect that the defendant is a defective delinquent, and may commit him to such a department for defective delinquents, according to his age and sex, as provided in section one hundred and seventeen of said chapter one hundred and twenty-three.

NOTE. — If the above form is used, sections 115, 120 and 123 will have to be amended to conform.

SECTION 3. Chapter nineteen of the General Laws is hereby amended by inserting after section four A, as amended, the following new section:—

Section 4B. In order that the Commissioner may receive or obtain the advice and judgment of leading men in the community in regard to the general policies and problems of the department, he is authorized, if he deems it necessary or advisable, to appoint a board which shall be known as the advisory council of the department of mental health. The council shall not exceed in number, and shall perform such duties as the commissioner shall from time to time assign to them. They shall receive no salary, but shall receive the necessary traveling and other expenses while in the performance of their official duties. Said board shall meet whenever requested so to do by the commissioner.

SECTION 4. Section forty-three of said chapter one hundred and twenty-three, as appearing in the Tercentenary Edition, is hereby repealed.

SECTION 5. Nothing in this act shall be deemed to terminate the employment or the term of office of the superintendent and the assistant physicians at the Westborough State Hospital, or any of them, in office immediately prior to the taking effect of this act.

SECTION 6. Section fifty-six of said chapter one hundred and twenty-three, as so appearing, is hereby repealed.

SECTION 7. Chapter one hundred and twenty-three of the General Laws is hereby amended by striking out section seventy-seven, as amended by section five of chapter three hundred and fourteen of the acts of nineteen hundred and thirty-five, and inserting in place thereof the following section:—

Section 77. If a person is found by two physicians qualified as provided in section fifty-three to be in such mental condition that his commitment to an institution for the insane is necessary for his proper care or observation, he may be committed by any judge mentioned in section fifty, to a state hospital, to the McLean hospital, or, in case such person is eligible for admission, to an institution established and maintained by the United States government, the person having charge of which is licensed under section thirty-four A, for a period of forty days pending the determination of his insanity. Within thirty days after such commitment the superintendent of the institution to which the person has been committed

shall discharge him if he is not insane, and shall notify the judge who committed him, or, if he is insane he shall report the patient's mental condition to the judge, with the recommendation that he shall be committed as an insane person, or discharged to the care of his guardian, relatives or friends if he is harmless and can properly be cared for by them. Within the said forty days the committing judge may authorize a discharge as aforesaid, or he may commit the patient to any institution for the insane as an insane person if, in his opinion, such commitment is necessary. If, in the opinion of the judge, additional medical testimony as to the mental condition of the alleged insane person is desirable, he may appoint a physician to examine and report thereon.

In case of the death, resignation or removal of the judge committing a person for observation, his successor in office, or, in case of the absence or disability of the judge committing a person as aforesaid, any judge or special justice of the same court, shall receive the notice or report provided for by this section and carry out any subsequent proceedings hereunder.

SECTION 8. Section sixty-six of said chapter one hundred and twenty-three, as appearing in the Tercentenary Edition, is hereby amended by adding at the end the following new paragraph: —

If a feeble-minded person is committed to such a school, the department shall thereafter have power, whenever advisable, to transfer him to the custody or supervision of the department; and thereafter the provisions of section sixty-six A, relative to removal, temporary release and discharge of feeble-minded persons, shall apply to such person.

SECTION 9. Said chapter one hundred and twenty-three is hereby further amended by striking out section seventy-nine, as amended by section seven of said chapter three hundred and fourteen, and inserting in place thereof the following: —

Section 79. The superintendent or manager of any institution for the insane may, when requested by a physician, member of the board of health, sheriff, deputy sheriff, member of the state police, selectman, police officer of a town, or by an agent of the institutions department of Boston, receive and care for in such institution as a patient, for a period not exceeding ten days, any person deemed by such superintendent or manager to be in need of immediate care and treatment because of mental derangement other than drunkenness. Such request for admission of a patient shall be put in writing and

be filed at the institution at the time of his reception, or within twenty-four hours thereafter, together with a statement in a form prescribed or approved by the department, giving such information as it deems appropriate. Any such patient deemed by the superintendent or manager not suitable for such care shall, upon the request of the superintendent or manager, be removed forthwith from the institution by the person requesting his reception, and, if he is not so removed, such person shall be liable to the commonwealth or to the person maintaining the private institution, as the case may be, for all reasonable expenses incurred under this section on account of the patient, which may be recovered in contract by the state treasurer or by such person, as the case may be. The superintendent or manager shall cause every such patient either to be examined by two physicians, qualified as provided in section fifty-three, and cause application to be made for his admission or commitment to such institution, or to be removed therefrom before the expiration of said period of ten days, unless he signs a request to remain therein under section eighty-six. Reasonable expenses incurred for the examination of the patient and his transportation to the institution shall be allowed, certified and paid as provided by section seventy-four.

SECTION 10. Section eighty of said chapter one hundred and twenty-three, as appearing in the Tercentenary Edition, is hereby amended by striking out, in the eighth line, the word "needing" and inserting in place thereof the following:—deemed by such superintendent or manager to be in need of,— so as to read as follows:— *Section 80.* The superintendent or manager of any institution to which commitments may be made under section sixty-two may, when requested by a physician, by a member of the board of health or a police officer of a town, by an agent of the institutions department of Boston, by a member of the state police, or by the wife, husband, guardian or, in the case of an unmarried person having no guardian, by the next of kin, receive and care for in such institution, as a patient for a period not exceeding fifteen days, any person deemed by such superintendent or manager to be in need of immediate care and treatment because he has become so addicted to the intemperate use of narcotics or stimulants that he has lost the power of self-control. Such request for the admission of a patient shall be made in writing and filed at the institution at the time of his reception, or

within twenty-four hours thereafter, together with a statement, in a form prescribed by the department having supervision of the institution, giving such information as it deems appropriate. The trustees, superintendent or manager of such institutions shall cause to be kept a record, in such form as the department having supervision of the institution requires, of each case treated therein, which shall at all times be open to the inspection of such department and its agents. Such record shall not be a public record, nor shall the same be received as evidence in any legal proceeding. The superintendent or manager of such an institution shall not detain any person received as above for more than fifteen days, unless, before the expiration of that period, such person has been committed under section sixty-two, or has signed a request to remain at said institution under section eighty-six.

SECTION 11. Section eighty-two of said chapter one hundred and twenty-three, as so appearing, is hereby amended by striking out, in the second line, the words "delirium tremens and", — so as to read as follows: — *Section 82.* No person suffering from insanity, mental derangement, deliriums, or mental confusions, except drunkenness, shall, except in case of emergency, be placed or detained in a lock-up, police station, city prison, house of detention, jail or other penal institution or place for the detention of criminals. If, in case of emergency, any such person is so placed or detained, he shall forthwith be examined by a physician and shall be furnished suitable medical care and nursing, and shall not be so detained for more than twelve hours. Any such person not so placed or detained who is arrested by or comes under the care or protection of the police, and any other such person who is in need of immediate care and treatment which cannot be provided without public expense, shall be cared for by the board of health of the town where such person may be. Such board of health shall cause such person to be examined by a physician as soon as possible, shall furnish him with suitable medical care and nursing, and shall cause him to be duly admitted or committed to an institution, unless prior to such admission or commitment he shall recover or be suitably provided for by his relatives or friends. Reasonable expenses for board, lodging, medical care, nursing, clothing and all other necessary expenses incurred by the board of health, under this section, shall be allowed, certified and paid in the same manner as provided by section seventy-four.

SECTION 12. Said chapter one hundred and twenty-three is hereby further amended by striking out section eighty-six, as amended by section eight of said chapter three hundred and fourteen, and inserting in place thereof the following:—

Section 86. The trustees, superintendent or manager of any institution to which an insane person, a dipsomaniac, an inebriate, or one addicted to the intemperate use of narcotics or stimulants, may be committed may receive and detain therein as a boarder and patient any person who is desirous of submitting himself to treatment, and who makes written application therefor and is mentally competent to make the application; and any such person who desires so to submit himself for treatment may make such written application. Except as otherwise hereinafter provided, no such person shall be detained more than three days after having given written notice of his intention or desire to leave the institution; provided, that if his condition is deemed by the trustees, superintendent or manager to be such that further hospital care is necessary and that he is no longer mentally competent to be detained therein as a voluntary patient, or that he could not be discharged from such institution with safety to himself and to others, said superintendent or manager shall cause forthwith application to be made for his commitment to an institution for the insane, and, during the pendency of such application, may detain him under the written application hereinbefore referred to.

SECTION 13. Section eighty-seven of said chapter one hundred and twenty-three, as so appearing, is hereby amended by striking out, in the eighth line, the words "three months" and inserting in place thereof the words:— ten days, — so as to read as follows:— *Section 87.* The trustees of the Monson state hospital may receive and detain therein as a patient any person who is certified to be subject to epilepsy by a physician qualified as provided in section fifty-three, and who desires to submit himself to treatment and makes written application therefor, and whose age and mental condition are such as to render him competent to make such application, or for whom application is made by a parent or guardian. No such patient shall be detained more than ten days after having given written notice of his intention or desire to leave the hospital. Upon the patient's reception at the hospital the superintendent shall report the particulars of the case to the department, which may investigate the same.

SECTION 14. Section twenty-three of said chapter one hundred and twenty-three, as so appearing, is hereby amended by striking out the entire section and substituting therefor the following:—

Section 23. If the department has reason to believe that an insane, epileptic or feeble-minded person who is a proper subject for treatment or custody in an institution is confined at public charge or otherwise, in any place not licensed by the department, the department shall have authority to visit the place of detention and to examine the patient. If the result of such examination discloses that said patient is a proper subject for treatment or custody in an institution, application shall be made to a judge for commitment of such person to an institution.

SECTION 15. Chapter one hundred and twenty-three of the General Laws is amended by striking out section thirty-six, as so appearing, and inserting in place thereof the following section:—

Section 36. The superintendent or head physician of each institution shall cause all implements or devices of restraint to be kept under lock and key when not in actual use.

SECTION 16. Chapter one hundred and twenty-three of the General Laws is further amended by adding to section forty, as so appearing, the following sentence:— Locked doors on buildings housing patients in institutions under the jurisdiction of the department shall not be construed as constituting an obstruction of egress within the meaning of any section of chapter one hundred and forty-three,— so as to read as follows:— *Section 40.* Each institution shall be provided with proper means of escape from fire and suitable apparatus for the extinguishment of fire, and no building shall be erected or maintained at such institution without a written certificate of approval from the building inspector of the department of public safety for the district in which it is to be erected or maintained. Locked doors on buildings housing patients in institutions under the jurisdiction of the department shall not be construed as constituting an obstruction of egress within the meaning of any section of chapter one hundred and forty-three.

SECTION 17. Chapter one hundred and twenty-three of the General Laws is hereby amended by inserting after section twenty-four, as appearing in the Tercentenary Edition, the following new section:—

Section 24A. The department may solicit and accept advertisements for insertion in the publication issued by it and known as the Bulletin of the Department of Mental Health. Section twenty-seven of chapter thirty shall apply to moneys received by the department for or on account of such advertisements; provided, that any net profits derived from such advertisements may be used in improving said publication or expended in connection with the issuance by the department of a publication concerning the hospitals and institutions under its control or under its general supervision, or in both such manners. All action by the department under authority of this section shall be subject to the approval of the commission on administration and finance.

APPENDIX 11.

A SURVEY OF THE MENTAL INSTITUTIONS OF MASSACHUSETTS.

Conducted by the MENTAL HOSPITAL SURVEY COMMITTEE.

MENTAL HOSPITAL SURVEY COMMITTEE.

Arthur P. Noyes, M.D., *Acting Chairman.*

S. Spafford Ackerly, M.D.
Louis Casamajor, M.D.
Ross McC. Chapman, M.D.
Franklin G. Ebaugh, M.D.
Clarence M. Hincks, M.D.
J. Allen Jackson, M.D.
Lawrence Kolb, M.D.

Bernard T. McGhie, M.D.
Winfred Overholser, M.D.
Frederick W. Parsons, M.D.
Arthur H. Ruggles, M.D.
William L. Russell, M.D.
H. Douglas Singer, M.D.

Participating Agencies.

The National Committee for Mental Hygiene
American Psychiatric Association
United States Public Health Service
American Medical Association
The American Board of Psychiatry and Neurology
American Neurological Association
The Canadian National Committee for Mental Hygiene
The Canadian Medical Association

Samuel W. Hamilton, M.D., *Director.*
Grover A. Kempf, M.D., *Associate Director.*

THE SURVEY.

I. THE OCCASION.

Administrative changes in the state hospital system of Massachusetts late in 1936 led to setting up a Special Commission on Mental Diseases by the Legislature of 1937. In the second year of its existence this Commission organized a formal survey of the institutions for the mentally sick, defective and epileptic. This task was entrusted to the Rev. Otis F. Kelly, a member of the Special Commission; Dr. Morgan B. Hodskins, one of the seniors among the state institution superintendents; and Dr. S. W. Hamilton, representing the

Mental Hospital Survey Committee, whose headquarters are in New York City.

The study proceeded intermittently through several months. A change in the plan of work was rendered necessary by the resignation of Father Kelly from the Special Commission, and by the illness of Dr. Hodskins. Dr. Grover A. Kempf, associate director of the Mental Hospital Survey Committee, then completed the study.

There is no lack of information on which to draw about the Massachusetts institutions. That Commonwealth has long been the one to set many of the standards in the field of mental hygiene, and its practices and its statistics are quoted in the professional and administrative literature of the whole country. Its published reports have been drawn upon here, together with fresh data from the statistical division of the State Department of Mental Health: reports in the files of the National Committee for Mental Hygiene on a variety of topics have been consulted; persons well acquainted with Massachusetts have been interviewed and information taken from the United States Bureau of the Census. Most of all, the institutional activities have been studied on the ground.

With much pleasure and sincere gratitude acknowledgment is made of the indebtedness of the surveyors to the member of the Special Commission and the representative of the institution staffs in showing the way through the hospitals and opening up the various problems of the situation. At the same time it must be made clear that this is in no sense their report, but purely that of the Mental Hospital Survey Committee staff. Wherever we differ from local authorities in our interpretation of conditions or in our recommendations for action, we have tried to present our reasons.

II. CENTRAL ORGANIZATION.

The Commissioner of Mental Health, appointed for a term of six years, has very considerable powers of inspection and supervision. His is obviously a position demanding expert knowledge and broadsighted leadership. The law provides an assistant commissioner and a director of mental hygiene to serve under the Commissioner. The Department has created positions, also, for an inspector, a director of statistics and research, and an assistant to the Commissioner. Several of these positions were recently filled after a period during which the Department was seriously understaffed. Following custom in

this State, several appointments were made from among the assistant superintendents.

There is also a business organization in the office of the Department. The number of functionaries in this field has recently been increased. It is expected that in this way the problems of finance, of building, and of operation will receive better and quicker attention; that activity will be expedited and due economy maintained.

Certainly in the professional field this organization is far from top-heavy. It is a practice to call to the Department some of the ablest assistant superintendents in the service, and good results are accordingly obtained. One might hope that a modification of this policy will be established in one regard. The inspection service should be strengthened so that more attention will be paid to the individual patient during the inspector's visit. There is not much experience in this country on which to assert that this added function has a value commensurate with its cost. One other commonwealth has carried it on for about three decades, apparently with advantage. If Massachusetts should decide to do the same, it will probably seem desirable to have a more permanent official than has previously been designated to this position; thus far each inspector has been looking forward to settling down into a superintendency.

The new Department has an unusual opportunity to serve the mentally sick and defective of Massachusetts. The peculiar circumstances under which it has come into office give to the Department an unusual incentive to freedom of action. Good precedents will, of course, be followed, but the situation encourages departures from custom much more than is usually the case. It is to be hoped that departures will be made. The history of the Massachusetts state service is indeed a distinguished record of ability on the part of those who directed it. Each of the able men who guided the course of the Department under its various titles was an innovator, and innovation is an essential of progress.

III. PLANT.

The Commonwealth has expended considerable sums under wise professional direction to meet the needs of the mentally sick. The first institution was opened in 1832, a handsome brick structure, and almost every type of architecture that

has been popular in the century since then is represented somewhere in the State.

Older buildings are constructed of brick or stone with wooden beams. Fire walls sometimes extend from basement to ceiling; nevertheless, the fire risk in such structures has been considerable. Of late many old stair wells have been torn out and replaced by non-burning elements. Sprinklers have been installed in some dangerous places. This program of reconstruction must continue for some years.

The height of buildings varies from the bungalow to four-story structures. Since the Department can obtain any architectural advice that it wishes, and the Special commission for whom this report is drawn has an architect member, it would be superfluous to enter on an argument regarding the most economical number of stories to which to build. Something, however, should be said about the matter from the standpoint of the patient.

For patients who are entirely bedridden any height of building is acceptable; there exist in another commonwealth some skyscrapers designed for such patients. It seems easy to forget that relatively few mental hospital patients are completely bedridden. To be sure, the number of old people entering the hospitals is increasing, but many of these, either at the time of admission or after they have received good medical and nursing attention for a few weeks, are quite able to get around. In practice, high buildings are never equipped with elevators on so liberal a scale that patients can be sent up and down at any given moment in considerable numbers. It should be remembered that public hospitals cannot, like commercial buildings, have a considerable organization of elevator operators, hence slower machines are installed, to be self-operated, and therefore to empty a ward of 30 or 60 patients by elevator service takes a long time. Since this is the case, extra personnel is necessary in order to get the patients out of doors, for only a few can go at a time, and they must be brought back the same way. This additional personnel may not be available at the moment when weather and the daily program unite to make the lawns inviting. In the better planned high buildings this difficulty is only partly solved by arranging considerable porch space on each story.

Four-story buildings are uncommon in Massachusetts except as a fourth story has been equipped to house personnel, but

they exist. Three-story buildings are common. Efforts are made in most hospitals to classify the patients so that the feebler ones will be on the ground floor, but this plan seldom works entirely well. In order to have patients out of doors easily and often, one and two story buildings are most effective. It may be remarked that the newest hospital in California has a large number of one-story structures. Apparently the mildness of the climate is not the only reason for this arrangement, since it prevails also in the newest institution in Illinois.

The so-called Kirkbride style consists of a central administrative and residential block, with other blocks attached and projecting to the side or to the back. These wings are usually homologous. This style prevailed in the second half of the previous century. It was modified at times by separating these blocks somewhat and running corridors between them.

A later development may be called the corridor type of institution, two admirable examples of which are in Massachusetts at Foxborough and Waltham. The corridors serve not only as passageways, but also as sitting rooms, for they are broad, well lighted and attractive. The principal section of the Metropolitan State Hospital at Waltham is built around a large enclosure available for sports, or preferably for scenic treatment. Around 1890 there came a movement for the development of institutions on the cottage plan. In time some of these "cottages" were built for 100 or 200 patients. Medfield is an interesting example of this type of institution, which, indeed, has many attractive and satisfactory features.

With the increasing demands for space in the hospitals, original plans have been extended or modified. This procedure is usually designed to save spending money in a particular year, and often brings quite uneconomical results in later years by breaking down one service function after another — laundry, storeroom, power plant, sewage disposal, water supply — so that they have to be replaced.

Most buildings in the Massachusetts institutions are in good style, with a reasonable degree of ornamentation and desirable proportions. Utilities did not always have adequate space in the older buildings, and plumbing at times was somewhat skimpy; but in most hospitals such faults have been corrected. Rooms for the nurses' utilities, record rooms and linen closets are not always adequate. Sections constructed for the disturbed are apt to have narrow corridors, perhaps

smaller rooms, and to be bare; but many disturbed groups have been shifted into newer structures.

Institutions generally have good assembly halls. A development of later years has been the use of such halls as gymnasias, in which case proper space for the storage of chairs is important. In an earlier period these halls were placed in the administration building on the second floor or even higher, but more modern ones are on the ground floor. An occupational building is usually some discarded structure that has been remodeled. Those that have been planned for their own purpose may be very beautiful.

Since this report is concerned with the care and treatment of the patients, but little has been or will be said about buildings. In general, the trends in Massachusetts may be commended, but one might issue a word of warning against allocating any building to an institution in disregard of the opinion and experience of its superintendent, as has been done in at least one instance. It seems unfortunate also that a hospital built according to a carefully worked out plan should then have its functions dislocated by forcing into the plant additional elements perhaps quite incoherent to the previous structures.

The money of the Commonwealth should be wisely and economically spent. This is sometimes the justification of authorities for adding a nondescript building to a plant, as, for instance, a building for prolonged cases instead of a more costly one for reception of new patients. In the long run this procedure is not economical. Every building should be carefully planned for a particular group.

IV. MEDICAL ORGANIZATION AND ACTIVITIES.

Each institution has a medical head, a medical staff of varied experience and acquirements, a business organization headed by a steward, and several department heads.

Superintendents have for years been men of experience and excellent training in psychiatry before they ever reached this grade. For some years it was the practice to give a physician who was likely to attain a superintendency a term in the Department during which he made inspection of all the hospitals, and to acquaint him in other ways with the activities of the Department. Indeed, this plan has only once been departed from recently. The advantages to the patients over whose needs the superintendent is to preside need not be dilated on.

He has a considerable measure of authority, and until recently the administration of the Department did not hamper those with the most energy and initiative from developing their special interests in the treatment of the patients and the development of the hospitals. Of course, this means that a superintendent also has opportunity to make some mistakes and to offer no little resistance to a new scheme that does not appear to him to be desirable. On the whole, this arrangement is better than what prevails in some more centralized services where tenure is less secure. Occasional mistakes and occasional opposition are much more than compensated in the ability of all these officers to plan ahead over a period of years and carry out their plans as facilities and support become available.

The next ranking officer is usually called the assistant superintendent. A few such positions have been filled by the appointment of able men from outside the State, and several instances could be mentioned in which this has been of very great benefit to the Massachusetts service. As a rule, the assistant superintendent has achieved his promotion in his own hospital; no examinations are given and promotion depends partly on chance, — the promotion or retirement of the man ahead, — and mostly on the judgment of the superintendent. A system of state-wide competition introduced into promotions to this grade would be to the advantage of the service.

Another medical position of considerable importance but not existing in every hospital is that of clinical director. He should be free from harassing administrative duties and be able to give a great deal of attention to the needs of the individual patients, to the details of treatment, and to the training of the younger physicians. None of the hospitals is so small that it should not have such an officer. A man of great clinical ability should be appointed to this position, and the salary should be such that one who is not ambitious to pass on to the superintendency through a period of administrative activity as first assistant should be content and comfortable on the salary available.

Another special position that Massachusetts for many years has sought to keep filled in every hospital is that of pathologist. In rank and emoluments he does not equal the medical officers already mentioned. There is a soundness and depth

about the medical service of an institution with a good pathological department that is hard to equal under other arrangements, and this is one of the reasons for the pre-eminence of Massachusetts institutions in the country. The supply of able pathologists is always small. Measures should be taken to hold them.

Several hospitals follow the plan of having one large medical office in which all the assistants except the assistant superintendent have desks. The usual argument is that it is desirable to have the physician near his records, and the records must be filed at the center. At a busy time of day one can see such a room with one physician attempting to use the dictaphone, another dictating to a stenographer, two talking with visitors about their patients, and others trying to do their paper work.

Since the physician should be near his patients, it is desirable that offices and examining rooms be installed on each medical service. To some extent this has been done in certain hospitals, but others are slow in following suit.

Salaries in Massachusetts are neither high nor low. They have always been respectable, but the Commonwealth has sometimes had to depend on the accessory advantages of pleasant environment and intellectual atmosphere to hold persons who had better offers elsewhere. The following table gives a few comparisons:

Salaries of Hospital Personnel, 1938.

[With maintenance.]

	Massachusetts.	New York.	Pennsylvania.
<i>Medical.</i>			
Superintendent	\$4,000-\$5,700	\$4,000-\$6,000	\$6,000-\$8,000
Assistant superintendent	3,300- 4,020	3,200- 4,000	3,732- 5,232
Clinical director	3,300- 4,020	3,200- 4,000	2,880- 5,232
Pathologist	2,520- 3,060	3,200- 4,000	2,592- 3,732
Senior physician	2,520- 3,060	2,400- 3,200	2,592- 3,732
Junior physician	1,800- 2,420	1,800- 2,400	1,500- 2,592
<i>Nursing.</i>			
Superintendent of nurses	\$2,040-\$2,400	\$2,000	\$1,632-\$2,232
Head nurse	1,080- 1,200	1,152	1,044- 1,304
Charge attendant	840- 1,080	\$792- \$838	900- 1,020
Attendant	540- 840	648- 792	660- 900
<i>Other.</i>			
Occupational therapist (chief) . .	\$1,200-\$1,560	\$1,500-\$1,900	\$1,284-\$1,824
Physical education instructor . . .	780- 1,080	\$1,200	924- 1,284
Psychologist	1,320- 1,800	-	1,392- 2,064
Social worker	1,800- 2,160	\$1,500-\$1,800	1,224- 2,232
Steward	2,280- 2,640	3,000- 4,000	3,000- 3,600

Source.

Massachusetts: Medical salaries: Data collected by the Mental Hospital Survey Committee, 1937. Other salaries: Schedule of salaries received from the Department of Mental Diseases.

New York: Handbook of the Department of Mental Hygiene, 1938.

Pennsylvania: Classification of the positions in . . . Pennsylvania . . . state-owned institutions, 1936.

The following table gives the number of medical positions in each institution exclusive of the superintendent, the census at the end of 1938, and the ratio of assistant physicians to patients:

	Census.	Assistant Physicians.	Ratio of Assistant Physicians to Patients.
Boston State Hospital	2,299	16	1:143.7
Danvers State Hospital	2,304	13	1:177.2
Foxborough State Hospital	1,426	8	1:178.3
Gardner State Hospital	1,424	8	1:178.0
Grafton State Hospital	1,535	8	1:191.9
Medfield State Hospital	1,813	9	1:201.4
Metropolitan State Hospital	1,846	8	1:230.8
Northampton State Hospital	2,021	10	1:202.1
Taunton State Hospital	1,659	11	1:150.8
Westborough State Hospital	1,564	10	1:156.4
Worcester State Hospital	2,349	13	1:180.7
Total	20,240	114	1:177.5

The American Psychiatric Association has recommended that a hospital that serves as a center for all mental hygiene activities in its district shall have a ratio of not less than 1 assistant physician to 150 patients. The Massachusetts institutions do carry this community function. It will be noted how closely they approach the desired standard. For comparison, a few institutions in other states are mentioned:

	Census.	Assistant Physicians.	Ratio of Assistant Physicians to Patients.
New York state hospitals (exclusive of two psychopathic hospitals).	66,432	391	1:169.9
Allentown, Pennsylvania, state hospital . . .	1,607	10	1:160.7
Delaware state hospital	1,127	9	1:125.2
St. Elizabeth's Hospital, Washington, D. C. .	5,836	42	1:135.7

Source.

New York: Data received from the New York State Department of Mental Hygiene, as of June 30, 1938.

Allentown and Delaware state hospitals: Data collected by the Mental Hospital Survey Committee, 1937 and 1938.

St. Elizabeth's Hospital: Census: Annual Report of the Secretary of the Interior, June 30, 1938.

Physicians: Data collected by the Mental Hospital Survey Committee, 1937 and 1938.

No standards have been set up as to the ratio of physicians to patients most desirable in institutions for mental defectives. In the country at large there is some little variation in the distribution of responsibilities in such an institution. Comparisons with other States have been here made:

	Census.	Assistant Physicians.	Ratio of Assistant Physicians to Patients.
<i>Institutions for Mental Defectives.</i>			
Belchertown state school	1,306	5	1 : 261.2
Walter E. Fernald state school	1,972	9	1 : 219.1
Wrentham state school	2,001	7	1 : 285.9
Total, Massachusetts	5,279	21	1 : 251.4
New York state schools for mental defectives .	14,275	51	1 : 279.9
Pennhurst (Pennsylvania) state school . . .	1,792	8	1 : 224.0
<i>Institutions for Epileptics.</i>			
Monson State Hospital	1,461	8	1 : 182.6
Craig Colony, New York	2,281	12	1 : 190.1
New Jersey State Village for Epileptics, Skillman.	1,446	7	1 : 206.6

Source.

Massachusetts: Data as of January 1, 1939, received from the office of the Commissioner of Mental Health.

New York: Data received from the New York State Department of Mental Hygiene, as of June 30, 1938.

Pennhurst State School: Census: Eighth Biennial Report of the Department of Welfare, May 31, 1936. Assistant Physicians: Data received February 6, 1939.

New Jersey State Village for Epileptics, Skillman: Annual Report, year ending June 30, 1936.

A study that goes beyond the usual standards for diagnosis and treatment and involves comparisons of groups of cases and the formulation of conclusions of wider scope than are required for the individual patient may be called research. Probably every physician at some time should attempt special studies that might be included under such a title. Systematic research, however, generally requires the co-operation of representatives of various disciplines — not only physicians with varied backgrounds of training, but also technicians of perhaps several types. Research is always in progress in the State of Massachusetts. Private funds have been added to state moneys, especially at the Boston State Hospital, the Worcester State Hospital and the Wrentham State School — a

very desirable combination of resources. The Boston Psychopathic Hospital has received grants from various sources at different times; very excellent studies have been put out from other institutions, also, and one would need to name almost every one of them to exhaust the list.

Since the studious physician is likely to be the ablest physician, it is greatly to the advantage of the Commonwealth that research shall be continued, stimulated and promoted. Its existence attracts keen minds among the younger physicians, and helps to retain those with more experience; it produces a very healthy emulation among the different hospitals.

Records are good in Massachusetts. As might be expected, there are variations. It must probably be agreed that the clearest, best arranged case records come from Boston institutions.

Histories of the patients prior to admission are most often taken by the social worker, and are generally good. If a physician takes such a record he is apt to make it short and rather skimpy of material on the personality. It is fortunate that social workers can procure such excellent documents, but certainly the physician should be able to do as much; he should review all information brought in by others and amplify it. Admission notes are usually good. Physical examinations are adequate; some are much better arranged than others. A mental status taken at one sitting and soon after admission is found in the records of the Boston hospitals only. Progress notes are usually good, but in one hospital they were to be found very much neglected. Laboratory reports are well filed. Dental records may enter the clinical history file after the patient's discharge; in some institutions, never.

The medical staffs of these hospitals sit together from two to six times a week. The superintendent, the assistant superintendent or the clinical director presides. The principal subject discussed is the individual patient, his history, his condition, and the nature of his mental illness. For presentation of the history a typewritten abstract is prepared by the physician who has been assigned to make special examination of the patient. The question of legal commitment is considered, and often takes up an undue part of the time of the staff to the suppression of the still more important questions of treatment. At other conferences pathological material is reported. At another type of meeting medical literature is reviewed, and special studies are presented by staff members. This confer-

ence system is, of course, most creditable, and in late years has been imitated by the staffs of general hospitals. In some institutions it is capable of improvement; any hospital that does not review systematically the current psychiatric literature should give serious thought to that lack. This, like other medical procedures, should be restudied from time to time.

Massachusetts has long recognized that the salary of the assistant physician is not adequate for the early acquirement of anywhere near all the books that are tools of his trade. Accordingly good medical libraries have been gradually accumulated. There is variety in the expertness of those who have these libraries in charge. A graduate librarian is likely to be the most efficient in making the books useful. Usually the same person has charge, also, of the general library from which reading matter is supplied to the patients.

Psychiatric service to several groups is offered in varying measure by these hospitals and schools:

1. Since it is desirable that a large part of the patients who leave the hospital should have the benefit of further supervision and medical advice for some time, physicians hold office hours in several places in the hospital district at stated times. Patients who are on visit may report their progress and receive counsel without undergoing the hardship of a trip back to the hospital, with perhaps loss of time from a needed job. This work should be carried on indefinitely.

2. Under statutory arrangement dating from the year 1919 the state institutions carry some responsibility in the field of public education. They are expected to examine each year all school children in their districts who are three years or more retarded. Of course, many other children are referred for an opinion at the same time. This is a very important and helpful arrangement, and any criticism refers to detail rather than principle. If a physician recommends that the child be treated in a special class, this arrangement must be carried out or the school superintendent is in peril of prosecution. The procedure has now been in use so many years that a large experience has accumulated, and it is probable that occasion should soon be found to review these clinical procedures and see what modification would make them even more useful than before.

3. Much clinical service is given to juvenile courts. This, too, is a very valuable service and in few places outside of Massachusetts do state hospitals and schools make themselves so useful in this field.

4. *Child Guidance.* — One hospital has developed a community clinic for children which has attained the best standards of the time, — standards formulated on the basis of experience in many parts of the country. At the moment this type of clinical study and advice is

intermittent for lack of trained personnel. Most of the institutions give occasional advice in this field.

5. *Service to Adults.* — Some of the hospitals arrange to have part of the time of their clinic physicians available for study and consultation on adult patients. Probably more of this service is given at the hospital, but it is often difficult to get the patient to lay aside his prejudices and seek treatment there. The Boston Psychopathic Hospital has the largest out-patient service. At the present time there is call for much more of this service. Fortunately, more physicians in private practice are devoting their attention to psychiatry, and it may be hoped that this need of the community is being met temporarily rather than permanently by the assignment of additional staff physician hours to such work.

6. *Teaching.* — A considerable number of the older staff members carry responsibility for the teaching of some group. Since the teaching function in any hospital organization tends to make its members more alert, observant and active, this feature of the Massachusetts state service is most gratifying.

7. The relation to the institutions of the schools of medicine is a very important matter. If young physicians are to have that knowledge of mental illness and mental medicine that will enable them to meet the needs of the communities in which they settle, they must learn these things at the mental hospitals. The three important schools of medicine in Boston have well-organized arrangements. Harvard and Boston University students are taught at the Boston Psychopathic Hospital; the course has the commendation of medical educators and involves the personal contact of students and patients that is so important in all types of medical learning. Boston University and Tufts do most of their teaching at the Boston State Hospital and the Metropolitan State Hospital. They also have a very happy arrangement by which a student spends from two weeks to three months in residence at one of several state hospitals. That students appreciate the value of such experience is, of course, to be expected. The practice has been very valuable also to the institutions, in that a considerable number of the present staff physicians were attracted to psychiatry through this experience during undergraduate years. Many staff physicians are responsible for the teaching of pupil nurses. Certain institutions also conduct classes for students of law, students of theology, students of psychology, students of social work, students of occupational therapy, students of laboratory technique, and sometimes other groups.

8. *Psychology.* — All the institutions employ a psychologist (usually under the title "psychometrist"), whose primary duties are in the school clinics and court clinics. Occasional service is given to adult patients in the hospital. Where research is carried on, highly qualified psychologists are found on the staff, several of them widely

respected for their contribution to our knowledge of the mental patient.

9. *Inter-Institutional Relations.* — Distances between institutions are not great in this Commonwealth. What might require more organization in some States is easy to bring about here.

The Commissioner is accustomed to call fairly frequent meetings of the superintendents; usually a meal is taken by all together in some convenient place in Boston, and business is discussed during and after the repast.

There are no similar stated sessions for the assistant physicians. Medical organizations to which most of the assistants belong furnish platforms from which to set forth special studies and discussions. These are the New England Society of Psychiatry, the Massachusetts Psychiatric Society, and the Boston Society of Psychiatry and Neurology.

The offer of the American Board of Psychiatry and Neurology to examine and certify experienced and well-equipped men as specialists in these branches of medical practice was eagerly accepted in Massachusetts. Pursuant to a demand by many of the assistant physicians for instruction in some of the topics with which they were less familiar, a course was organized at the Metropolitan State Hospital. It has been given four times and has undergone no little expansion. It is possible for any assistant physician to drive to Waltham, spend the day, and go home at night, and this is being done by a considerable number.

The hospitals that are most active and best known in the teaching of research often receive a fellow in psychiatry from the National Committee for Mental Hygiene or one of the foundations. In this way selected physicians from many parts of the country have benefited from and made their contributions to the Massachusetts state service.

Each superintendent has carefully studied his positions, and when opportunity offers to make a promotion he is guided by the usual criteria of length of service, diligence and adaptation to hospital needs. It is probable that still better results can be obtained by giving candidates for promotion a suitable examination. Basic requirements should be laid down by the Department, including length of service, interne experience, and scope of examination. Not all these examinations need be competitive if the State will arrange to give promotions in the lower grades to every one who will earn it.

The exigencies of out-patient service have sometimes been

met by placing physicians therein with only meager special training. Better provision should be made. This matter requires oversight by the Department, and assurance to every superintendent that on need he can get a man or woman who has had the requisite training for undertaking such work with the prospect of success.

No system has been arrived at by which physicians will routinely get experience in different types of institutions. Sometimes this has been arranged on the initiative of the individual. Perhaps a physician has been more available to fill a post at another institution than was any one on the resident staff. There have been physicians at the schools and at the hospital for convulsive disorders who, after several years of service, have found it difficult to move to a hospital for the different and important experience available there without accepting a decrease in salary that might be embarrassing to a man with a family. For the strengthening of the service it would seem desirable to make such arrangements as would assure a physician who wishes it an occasional period of work in an institution of different type from the one that he elects for his principal service.

V. NURSING.

Nursing in the hospitals may be organized in one group, or in two. If the organization is unified, the superintendent of nurses is at the head and has both male and female assistants. In the two-headed organization there is a chief supervisor for the men's service, and the superintendent of nurses serves the women; the two function independently and report direct to the administrative medical service. There is, of course, room for difference of opinion on the merits of these two organizations, and the personal qualifications of some incumbent of an important position must at times be the deciding factor in the scheme chosen.

Graduate and registered nurses are sought for important positions in the nursing service, and a considerable number have been employed. This number fluctuates from time to time.

Certain hospitals maintain a three-year course in nursing. The superintendent of nurses is at the head of the school and usually has quite adequate help from the medical staff in lecturing. Reviews and instruction on the wards might in some

instances be strengthened. The student spends a year in some general hospital learning techniques in medicine and surgery that can better be taught there. Graduates of such a course take the usual licensing examination and become registered nurses.

Several hospitals are giving a two-year course of nursing. The studies are usually pursued earnestly. Students are somewhat older than the group that ordinarily enters the school of the general hospital in these days. They do a full day's work, and pursue their study afterward. Their diplomas are of limited use to them outside the mental hospital; but such trainees are of very great value, and their services are widely desired in hospitals here and elsewhere.

No suitable provision exists by which a man can get full training in nursing in these institutions. A few have been admitted to the two-year course and are, of course, very valuable to the institutions after that period of study. Since there are so many nursing positions for men, not only in mental but also in other types of hospitals in this country (over 16,000), and since there are so few graduate male nurses (about 600), it is desirable that in every section of the country there shall be at least one good school for men. Certain difficulties are experienced in finding and holding the best type of young man for training as a nurse, but it can be done and is being done successfully. Certainly every mental hospital considers itself fortunate whenever a capable trained man is added to its organization, and the Commonwealth ought to be training some.

These are unskilled persons when employed (attendants) and are taught largely by the apprentice system after they enter the hospital service. A course of lectures and demonstrations for attendants is prescribed by the Department. Hospitals differ in the frequency with which this course is repeated. It appears to be well conceived.

The following table covers the hospitals only, not the schools. It shows the nursing personnel, population at the end of 1938, and the ratio:

HOSPITAL.	Census.	Number of Nurses and Attendants.	Ratio of Nurses and Attendants to Patients.
Boston State Hospital	2,299	464	1 : 5.0
Danvers State Hospital	2,304	344	1 : 6.7
Foxborough State Hospital	1,426	185	1 : 7.7
Gardner State Hospital	1,424	185	1 : 7.7
Grafton State Hospital	1,535	212	1 : 7.2
Medfield State Hospital	1,813	278	1 : 6.5
Metropolitan State Hospital	1,846	258	1 : 7.2
Northampton State Hospital	2,021	290	1 : 7.0
Taunton State Hospital	1,659	262	1 : 6.3
Westborough State Hospital	1,564	227	1 : 6.9
Worcester State Hospital	2,349	380	1 : 6.2
Total	20,240	3,085	1 : 6.6

This is a creditable showing. The Boston State Hospital leads with 1 : 5, which is unusual except in institutions of rapid turnover like the Psychopathic Hospital. Perhaps some institutions have assigned too many attendants to other duties, and therefore give poorer service to their patients than the record shows.

Nursing salaries are perhaps adequate for the present, when great numbers of people are out of work. This situation might be quickly changed. The point that should always be stressed in a consideration of certain salaries is that the head nurse or charge attendant carries a great responsibility. In the direction of a unit, commonly called a ward or a cottage, there may be one or several subordinates. This should be a position of honor and should carry a large enough salary so that changes will be infrequent. It is recommended that in any revision of the salary schedule the emoluments of this position shall be increased.

Nursing personnel is generally provided with suitable rooms away from the wards. The large increases in personnel called for by the growing census and by the addition of a third nursing shift have led to granting larger sums for commutation of quarters. Certainly married people should be encouraged to live outside, and some single folks. Experience shows that a considerable fraction of the unmarried employees work more steadily if quartered on the hospital premises.

As one goes about the institutions of Massachusetts, he develops a growing appreciation of the intelligence, alertness, attentiveness and general capacity of the nursing personnel of both sexes. No doubt the years of depression have brought into the service persons with a higher average of education than usual, but one who has seen the institutions over many years must testify that the type of administration, the security experienced by those who are interested in their duties, and the general level of public service in this Commonwealth, all play a part in the excellent standards of the institutions.

VI. FOOD: SOURCE, PREPARATION, SERVICE.

Foodstuffs are raised in considerable quantity on the hospital and school farms. Expert advice is obtained from an agricultural college about most of the procedures, and farms appear to be well managed and fertile. Most purchases of food are made by a central department on requisition from the Department of Mental Health.

The allowance for food purchase for the year ending November 30, 1936, varied from 11½ cents a day at Gardner State Hospital to 23½ cents at Metropolitan State Hospital, with an average of 15½ cents a day at the state schools. In addition, large quantities of foodstuffs are raised at Gardner and other hospitals that have extensive farms. A standard ration set up by the Department assures an adequate and balanced diet. The Department should and doubtless has reviewed all information assembled by the Special Commission on Mental Diseases and decided whether more is needed.

A dietitian is regularly in charge of food preparation. She usually reports to the steward on her activities. It is possible to get women of experience and ability for these positions. It is said that good cooks are available in adequate number and have been for several years. During prosperous times this situation changes for the worse.

Every institution has good kitchens. In some instances further improvements are planned. Some of the newer buildings, such as that at the Metropolitan State Hospital, are striking in the arrangement of facilities and the beauty of the apparatus. The bake shop is generally adjacent to the kitchen and the butcher shop at a convenient distance. Sometimes storage facilities are under the same roof with the kitchen, though under different administration.

Food is generally well cooked and almost invariably arrives at the dining room hot and attractive.

Every institution has both large dining rooms and small. Table service is usually from insulated carts. Well-equipped pantries for the small dining rooms are the rule.

The dietitian is usually responsible for the serving of food in any congregate dining room, but the nursing organization designates those who determine whether a patient has eaten adequately and take appropriate action. The nursing organization carries entire responsibility for smaller dining rooms which accommodate disturbed patients, and those in buildings at a distance from the centers of hospital activity.

The cafeteria has become popular in this State as elsewhere; indeed, two of the earliest mental hospital cafeterias were those at Westborough and Worcester, and the one giving the broadest choice of items in this country is at Taunton. Service in these cafeterias is usually well organized. Both patients and employees who work there are uniformed attractively and trained to give prompt service, but not to hurry their patients. A weak spot at some of the hospitals is the excessive number of patients allowed to start for the dining room at one time, causing too long periods of standing before reaching the food counter. The layout of the hospital has something to do with this difficulty, which, however, has been overcome in several institutions.

Patients are generally allowed to choose whatever table they will when they have received their food. Since dishes are heated before they are put in use, the patient's meal is appetizing when he gets seated, except that carrying the liquids that he will drink results in slopping. Members of the nursing personnel watch those who are inclined to eat too little and make sure (if necessary) that they have second helpings.

Different arrangements prevail for assembling the dishes afterward, and there is considerable variation in the comfort with which the patients leave the place.

As for the smaller dining rooms, variation in standards exists there. In some places food is likely to be cold before it is eaten. On the other hand, one finds dining rooms for quite disturbed patients in which excellent standards of conduct are observed, to the great benefit of all concerned.

In order to fit the meals into the working hours of employees whose time is limited to eight hours, there are some institutions that serve supper inordinately early and make no provision for refreshment by a bedtime snack, neither for the new patient

who has till recently been on an entirely different schedule, nor for the working patient who is doing heavy manual labor. This is one of the difficulties that trouble institution managements in days of transition. A good spacing of meals is an important health measure.

On the whole, the Commonwealth may be proud of the handling of the food problem. In some places the functioning is better than at others.

VII. GROUPS OF PATIENTS AND METHODS OF TREATMENT.

Some patients are brought to the hospital by relatives or friends. A large number are accompanied by peace officers. In the metropolitan area, from which there are many such patients to move from the Boston Psychopathic Hospital to other institutions, a considerable measure of skill has been developed by the transportation officers. To be sure, the sheriff or policeman will maintain a kindly attitude, but they are not nurses and their preparation for this type of work has not been systematic; their efficiency is not at all to be compared with that of hospital employees trained for the task. The old Commonwealth of Virginia and the young State of Idaho both send hospital employees from the state hospital for the new patient, on notification of the issuance of a court order. Certainly the employment of the police for this function is far below the general nursing standards of Massachusetts. It is to be hoped that this unfortunate procedure will quickly be corrected.

The reception accommodations vary considerably. In some institutions the patient comes into the main office and may feel that he is being stared at by clerks, by officials, by business persons who have come to see the steward, and by casual visitors. He is seen by a physician. If he has to come into the main medical office, there is no privacy for the interview. Fortunately, the more recent and better standard of a separate reception building at a little distance from the main group, with a comfortable and preferably attractive reception room where the physician makes his first acquaintance with the case, is gradually being extended to all institutions.

Of the hospital personnel, the first to greet and look after the needs of the new patient is usually a supervisor or some other representative of the nursing personnel; but a social worker is occasionally designated for this function. In some institutions the reception wards are well arranged for the new patient by being small and having in them only patients with an appear-

ance of freshness and an air of recovery. In others, the new-comer immediately sees other patients who have been long ill or who at the moment are desperately ill. This is hardly an encouraging companionship for one who comes in fearful and gloomy about his own future.

It has already been remarked that the state hospitals and state schools of Massachusetts have competent staffs of attending specialists. In general, such branches of medical practice as surgery, gynecology, orthopedics, ophthalmology and several more receive quite adequate attention; that is, the resident staff gives such examinations and treatment as are ordinarily adequate, and in cases that go beyond their experience the attending staffs are called in to advise or operate. Perhaps there is room for improvement, and it may be that hospitals should resurvey their resident population with a view to determine whether there are hernias, hemorrhoids, varicose veins, or other disorders that could be helped by the surgeon; whether there are cases of diabetes or duodenal ulcer or chronic bronchitis or arthritis in which a consultant would recommend still more effective remedies than those that are now in use. One comes away from visits to these institutions with gratification at the active attention regularly accorded the patient, but it is not intended in this report to indicate that these or any other medical groups may ever rest on their laurels. One must always be searching for more and better methods of treatment.

Many of the institutions are equipped with good surgical suites, and the attending surgeon performs any necessary operation there. Hospitals that are not so well equipped have made arrangements with general hospitals in the neighborhood, so that a patient is taken to a very good place for the operation and perhaps brought back at once to the mental hospital. This is a fair arrangement when none better is available. It should be remembered, however, that sometimes patients with annoying types of conduct require surgical treatment, and such a patient may be so feeble or otherwise impaired after the operation that removal several miles to his own institution for post-operative care is not the best plan.

In the case of the Fernald School, it is quite convenient to send surgical patients a short distance to the Metropolitan State Hospital, where they may stay as long as necessary.

Dental work is generally well attended to. The number of resident dentists in the institutions is noted on a previous page.

It was once remarked that the branch of medical activity perhaps best provided for in American mental hospitals is dentistry; certainly very creditable work is being done. There are places where a dental hygienist would add to the effectiveness of the program.

In every hospital one finds variation of interest in the use of various kinds of apparatus for the treatment of the incidental ills — sometimes, indeed, severe — that can be reached in such ways. Stimulative hydrotherapy, heat applied in various ways (most conveniently, perhaps, by electric current, direct or induced), and other measures of like sort are found located usually near the wards where the largest number of physically ill are cared for. There is a field of great usefulness here, and often it is well for some physician to specialize in such matters, and be commissioned by the superintendent to organize them in a convenient place with a competent personnel in charge. Certainly a considerable number of patients are improved in mood as well as in body if given the personal attention employed in massage, in treatment by light, in hydrotherapy and other such measures.

Hydrotherapy requires a special ward, particularly in regard to the use of the prolonged bath for the quieting of excitement and the induction of sleep. Installations for this therapy are found in all the hospitals. There is considerable difference in the extent to which they are used, depending largely on the convictions of the superintendent and to some extent on the convenience of the facilities; for instance it was noted in one hospital that certain tubs close to wards for disturbed patients were much used; that other tubs placed in a basement were less used. It may not be feasible to withdraw one or more employees from a ward two or three floors away — or even one floor away — and send them to this special room. More often than not, the patient is confined to the tub by some sort of a canvas sheet over it. This is not the ideal arrangement, for the bath should be a place of freedom. To covers that merely protect the æsthetic sense of the onlooker, no objection can be raised.

One hospital makes more use of this treatment apparently than any other. Special apparatus has been devised for the control of temperature in the tubs. This is also being installed in other places. It is very fine and may be recommended where funds are available. But let no one be misled into thinking that

the apparatus is the essential thing. The prolonged bath can be given in any bathtub when one especially equipped is not available.

For some years the Department has made available to the hospitals the special services of a physician who has given her attention to hydrotherapeutic procedure and some other items of physiotherapy till she is recognized throughout the country as a leading authority. This is a very fine arrangement, going beyond what any other similar state service has attempted. This physician not only discusses such matters with the resident staff, but she also devotes considerable time to training special personnel in very careful and effective fashion.

It is related that certain Arabian physicians in the Middle Ages organized occupations for the benefit of their mental patients. Recognition that work is good for the mentally sick as well as for the mentally sound is certainly ancient; nevertheless, the way in which the crafts have been organized for the benefit of the patients during the current century is perhaps somewhat more systematic than was older practice. Various allocations of responsibilities in this field are found in different sections of the country.

In Massachusetts the greater number of types of shop employment are embraced in the department of occupational therapy, and those in charge of such departments are graduates of special schools which give, indeed, an admirable training. Certain other occupations are embraced in a department of industrial therapy, and it is usually not expected of the craftsmen who supervise the repair of shoes, the weaving of towelling, or the repair of kitchenware, that they exercise as much ingenuity in following the changes in the patients' attention and interest as should be done by the occupational therapy aides. To put the matter in another way, those who are likely to work with a measure of steadiness are sent to the industrial shop, the laundry, the sewing room or the farm, whereas those whose response is less reliable are directed into occupational therapy. Some of these departments are particularly fine, and many of them must seem to be models to patients who may have come from some less enlightened section.

Superintendents usually wish that they could increase their occupational therapy personnel, and in this they should be encouraged so far as it is economically possible. In the long run it is cheaper for the Commonwealth to persuade a patient

to be usefully active than to allow him to vegetate and perhaps develop an antagonistic attitude. Since one could hardly run controlled experiments in this field, what has just been stated so confidently is difficult to prove; but it is the common testimony of those with experience.

The organizing of competitive sports for the benefit of the patients has not yet proceeded to the level of greatest usefulness, though considerable progress has been made. Only within relatively few years has an adequate supply of teachers of physical education been available from schools of education and universities. Such teachers can now be obtained. After appointment to the hospital they must pass a period of apprenticeship in learning about the manifestations of mental illness and how to meet the special requirements in this field. Interest has been shown by certain educational institutions in having part of the training of their students done in mental hospitals. In this way the supply of competent personnel should become still more accessible.

There is need in some of the hospitals of skilled directors supplemented by assigned attendants, so that patients may have the benefits not merely of recreation but also the more definite benefit of a sport program that is adjusted to their particular needs. Perhaps men are more quickly responsive to this than to almost any other approach, and it is hoped that the male patients may have quite competent treatment of this sort in every hospital shortly. The positions of director and assistant should be placed on every hospital pay roll.

Music therapy is often considered a minor matter, though it is generally recognized that group singing brings great enjoyment and improvement of mood to both normal and abnormal people. In skilled hands the use of music and the dramatic arts is organized in a way that may be somewhat comparable with physical education and occupational therapy. This field should be cultivated, and what is done now in Massachusetts may well be expanded into the hospitals that are making less use of it. The music director should be scheduled in the pay roll.

Recreation is considered of sufficient importance so that it is an item in the minimal standards set up by the American Psychiatric Association for mental hospitals. It may be said that each of the hospitals in this State has a good and varied program in this field.

Each hospital has a library for the patients. There is variation in the effectiveness with which they are administered. A librarian who will study the needs as well as the desires of the individual patients, particularly those who have recently left home, can be of great help in promoting an ameliorative program. Early demonstration of this was made at McLean Hospital. The word "bibliotherapy" is not fanciful, for courses of well-selected reading have helped many a patient. Very commendable work is done in several of the hospitals. There is still opportunity for the development of this matter.

Religious services are scheduled in every institution, and those with varying religious inclinations receive attention from clergymen of appropriate faith. Probably somewhat too little pastoral service is expected; if organized, such service is helpful to many patients. Some institutions serve as fields for the training of ministerial students, and this arrangement might probably be extended.

In one instance a state official offered the criticism that undertakers were not employed as required by law for the transportation of the deceased. He apparently overlooked the fact that the Legislature consistently appropriated too little money to carry out this requirement. The Legislature of 1938 appointed a recess commission to study this situation. This survey ascertained that the general custom is to have burial services conducted not only decently but also in accordance with the sensibilities of friends and other citizens.

Human beings quite generally object to limitation of their freedom of movement, and, so far as possible, this objection should be respected. The tendency therefore to use mechanical restraint except as a legitimate means of treatment should be deprecated — and combated. Reducing the amount of mechanical restraint to the lowest desirable figure may be said to depend on three things:

1. The conviction and energy of the physician.
2. The ability of the nursing personnel.
3. The adequacy of provision of measures of treatment, such as hydrotherapy, physical activity and interesting occupation.

The record of Massachusetts is creditable in this regard. In the following list is noted the number of cases reported in restraint during the month of October, 1938:

INSTITUTION.	Average Daily Patient Population.	PATIENTS UNDER RESTRAINT. ¹	
		Number.	Per Cent.
Boston State Hospital	2,384	—	—
Danvers State Hospital	2,310	26	1.12
Foxborough State Hospital	1,406	10	.71
Gardner State Hospital	1,435	1	.07
Grafton State Hospital	1,523	—	—
Medfield State Hospital	1,820	10	.54
Metropolitan State Hospital	1,865	2	.10
Northampton State Hospital	2,033	20	.98
Taunton State Hospital	1,689	20	1.18
Westborough State Hospital	1,592	11	.69
Worcester State Hospital	2,358	48	2.03

¹ These figures cover mechanical restraint only.

Human beings at times wish to be by themselves and unmolested by any other person, but forced separation from one's fellows often meets objection. It is sometimes necessary to protect other persons, and still more to protect the aggressive individual from suffering at the hands of others, presumably for his aggression. If the patient is in a room by himself and cannot get out because the door is locked or otherwise fastened, he may be considered to be in seclusion. Since seclusion is officially frowned upon, and therefore some stigma attaches to reports of patients so managed, the word is defined in various ways, either officially or otherwise. Officially in Massachusetts a patient is in seclusion only if fastened into a room between the hours of 7 A.M. and 6 P.M. Official statistics therefore make no record of the number of doors fastened at night. Unofficially there is a tendency to think, if the door is not locked but held closed by a piece of cloth or paper squeezed between the door and the jamb, that the case is hardly reportable.

This is a practice that needs review. In many regards seclusion is much less objectionable than restraint, but it can be used too freely. The fault, however, may not lie at all with those who are looking after the patients, but with those who control the appropriations. It may be remarked that some difficulties have been created by going from the two-shift to the three-shift system of nursing in most of these institutions, and the wards where some restless patients are quartered may

be rather thinly covered during one of the shifts. Again let tribute be paid to the good medical and nursing service of the institutions, but at the same time one may say that this is another of those measures that need frequent restudy.

Mental hospitals are not expected to receive defective (feeble-minded) persons unless they have in addition a mental illness; circumstances would seldom arise in which a person with pure defect would be admitted. On the other hand, in the course of years a considerable number of defectives develop mental illnesses while at the state schools. They are then committed to the state hospital. The school proceeds to admit some one from its ponderous waiting list, and when the original patient has recovered from his mental disorder there is no place for him in the school. He had already shown his inability to get along in the community and may not have developed any greater capacity. The mental hospital must, therefore, keep him. Fortunately, some of these patients are suitable for boarding out, and the hospitals to which they go will be able to place some of them in that way. Others, whose sex activity is undisciplined, will continue to occupy beds in the mental hospitals until the Commonwealth has further expanded its training school capacity.

The aged and infirm have increased so greatly in number of late years that they have overrun their accommodations in many institutions and now occupy wards that are not especially suitable for them. Generally speaking, it has been attempted in the mental hospitals and in the schools to place infirm people on the ground floor as far as possible. An argument for one-story buildings for the care of this type of person is well grounded. The example of the State of Illinois might be adduced to indicate that such a program is possible even in a region where cold weather often prevails. Buildings at Monson and at the schools are in point. Structural requirements for economy of movement on the part of the nurses are well understood: wards near the ground level, ramps in suitable places, wheel-chair pavilions or porches, dormitories not too large but easy of supervision, single rooms for patients who disturb others or who may be near the end of life, well-equipped utility rooms, and the like. There is still much study to be made of the physiology and pathology of old age, and important facts may yet be collected in mental hospitals.

Tuberculosis is found through all levels of society. It is likely to do most damage where it is unrecognized, where

human beings are crowded together, and where exercise and ventilation are neglected. Ordinarily a careful study of a mental hospital population in this section of the country will show that up to 5 per cent of the patients are infected. If treatment programs are good, many of this 5 per cent already have arrested lesions; that is, the disease has ceased to progress and the patient can live under mild restrictions an active and normal life. Of course, the type of life that he actually lives depends more upon his mental illness than upon his pulmonary damage.

The simplest arrangement for the care of these cases is to diagnose them by physical signs, — loss of weight, cough, pallor, fever or other obvious symptoms, — and then isolate them in whatever quarters may be available. Under this scheme they are already advanced cases when diagnosed, and the isolation is apt to be faulty, with peril both to other patients and personnel. Better hospitals provide ample diagnostic facilities and special buildings, or at least special wards, and every necessary attention to nursing, to diet, to graduated activity, to proper exposure to outdoor air and light, and to other established measures of treatment.

Several Massachusetts institutions are now well equipped to give all these measures of treatment and also to provide surgical procedures that of late years have been found most useful. Some physician on the hospital staff carries these patients as well as others on his service, and usually has assistance from a consultant who is an expert in the treatment of tuberculosis.

The opening of a new tuberculosis building at one hospital may be the occasion for the transfer of a few cases from other hospitals, especially if the provision in the older institution is not such that the most dangerous cases (that is, those most likely to spread the disease) can be properly isolated. There have not been in any one institution enough cases to warrant appointing to take charge of them a physician who is already expert in their treatment.

Experience elsewhere indicates that perhaps the best way to manage this problem is to bring together from several institutions those patients that have pulmonary tuberculosis and place them under treatment on a special service under the direction of some one who may, indeed, have had little psychiatric experience, but who can direct all the best measures for the physical disorder. Consideration should be given to such

an arrangement for all the cases that are in the eastern end of Massachusetts.

Some of the fundamentals of hygiene should be reviewed. Temperature is disregarded in some institutions, and wards are kept at an unconscionable heat. Frequently one finds no thermometer on a ward. Ventilation also is disregarded and sitting rooms and bedrooms become stuffy.

In many hospitals there are patients who may never leave the building from October to May. Some of these are the most disturbed patients, but others could hardly be so described. The situation is relieved in some instances by going to and from a congregate dining room three times a day, and in others, by the availability of porches. Reasons offered for not taking patients out of doors are that they are too disturbed, that they prefer not to go, or that they have not sufficient heavy clothing.

The care of the face is usually well looked after, barbers of reasonable skill being appointed to serve the men. Hospitals have also hairdressing parlors for women, and a large number receive those attentions that do much to rebuild the shaken self-esteem.

Clothing generally is adequate, but there is too much variation in the efforts that are made to keep the men presentable. More attention is paid to the fit of shoes than was once the practice, but further improvement could be made in some institutions.

Bathing apparently is given quite adequate attention. Most wards have some bathing facilities, and their frequent use in summer is much appreciated. Central bathing is employed occasionally, and it may be difficult for a patient to get an extra bath when he is hot and sticky.

Several hospitals employ a podiatrist to come at stated intervals and relieve the foot ailments of the patient. This is a very merciful arrangement.

Visiting has been encouraged in Massachusetts to such an extent that a physician expects to interrupt whatever he is doing in order to talk with relatives. The matter should be better organized. It is not good treatment for a patient to have an interview interrupted at perhaps a critical time, and the physician called away. The matter can be adjusted if undue pressures are removed. Certain days and hours should be set for discussions with the physicians.

Contrasts in the number of patients that are allowed to go about the grounds without supervision may depend on several

elements. The location of the hospital, whether in city or country, makes considerable difference in this regard. The layout of the hospital may make a difference; a hospital in Michigan has an enclosed park of eleven acres, where a forgetful patient may go about quite happy who might wander away under other conditions. The frequency of admissions is of consequence; where admissions are fewer and the hospital population is more stable, a larger number of patients can be left to their own devices. The policy of the institution may be determined by the temperament of some officer who may be more or less cautious.

The approximate number having ground privileges in several institutions on January 1, 1939, is set forth in the following table:

INSTITUTION.	Census.	GROUND PRIVILEGES.	
		Patients.	Per Cent.
Boston State Hospital	2,299	133	5.8
Foxborough State Hospital	1,426	173	12.1
Medfield State Hospital	1,813	400	22.1
Metropolitan State Hospital	1,846	223	12.1
Northampton State Hospital	2,021	207	10.2
Taunton State Hospital	1,659	250	15.1
Westborough State Hospital	1,564	433	27.7
Worcester State Hospital	2,349	626	26.6

Many patients on leaving the hospital are carried on the books for a year. This arrangement enables the staff to give a measure of supervision and help through its social service, and is a valuable extension of treatment and a type of insurance against relapse by those who must go to an environment with which they are out of sympathy.

If relatives insist on removing a patient against the advice of the hospital physicians, it is customary here to carry the patient as "on visit" in order that the formalities of readmission may not be a cause of delay in returning, and that various superfluous reports may not become necessary. This policy is to be commended. Such relatives are commonly required to sign a statement saying that the removal is against advice. Perhaps such a statement is required even in some instances

where the record indicates that the physicians are really in favor of the removal, as a precautionary measure against unwarranted criticism.

The only large reservoir of mentally ill patients outside the state hospitals is the mental wards of the State Infirmery at Tewksbury. Their patients are all transfers from the other wards of the State Infirmery. The Department of Mental Health has some authority over these transfers and a general supervisory function. It has long been thought that the better standards of the state hospitals should be extended to these patients, numbering about 500, but no serious movement is under way at the present time to provide for them. This question should receive a definite decision.

VIII. ACTIVITIES OUTSIDE THE INSTITUTION.

A vast amount has been done in the field of public education in the Commonwealth of Massachusetts. The Massachusetts Society for Mental Hygiene which engages in that work is one of the oldest of such bodies. It is well organized, has the support of many able and public-spirited men and women, and has had adequate funds for a considerable program.

Many hospital officers and department heads in the state service have contributed to this campaign. It is probable that the abbreviation of the recent political raid upon the institutions can be traced to the fact that the Department and its several institutions have taken the public into their confidence about their activities and their difficulties during previous years.

Follow-up work, as it is sometimes called, has long been practiced in this State. The following table shows the number of social workers in each institution. They have various other duties than the supervision of the patient on visit, but in all instances some of them are engaged in hospital supervision.

INSTITUTION.	Quota of Social Workers.
Boston State Hospital	5
Danvers State Hospital	4
Foxborough State Hospital	3
Gardner State Hospital	3
Grafton State Hospital	1
Medfield State Hospital	3
Metropolitan State Hospital	2
Northampton State Hospital	3
Taunton State Hospital	3
Westborough State Hospital	3
Worcester State Hospital	4
Monson State Hospital	2
Belchertown State School	3
Walter E. Fernald State School	3
Wrentham State School	2

No modern hospital of any type can expect to get the best possible results except by a good follow-up system, and the mental hospitals of Massachusetts have done wisely in organizing this field.

As indicated in the previous paragraph, a large part of the activity of the social workers is actually social service. In addition they take a very large number of histories of patients. As a rule, these histories are arranged excellently, stated clearly and seldom verbose. For the physician they illuminate the problems of the patients involved.

In some hospitals the social worker has considerable responsibilities for the new patient, not only in getting acquainted, but also in explaining the situation which is not only novel to him but perhaps also terrifying. This is a valuable assignment if social workers are numerous enough so that they will not have to neglect the things that no one else can do while attending to things that might be assigned to some one else.

Social workers have many duties in connection with the out-patient clinics, the school clinics and the juvenile court clinics. As noted in the section on "Medical Activities," these institutions carry considerable responsibility in those fields.

The social worker prepares the way for the physician, obtains vital facts, and enables the local social organizations to understand and profit by the observations of the psychiatrist.

In the aggregate a vast clinical service is performed for the citizens of Massachusetts who are not in the hospitals, particularly for its children, by the staffs of these hospitals. A mere enumeration of the places where work is done is impressive. A study of the schedules is still more impressive. One can hardly overstress the value to the community of placing at its service the experience of the institution psychiatrists.

We have not attempted to give an estimate of time spent on school or court service. Out-patient clinics are maintained in 50 cities and towns.

Massachusetts was the first American Commonwealth to undertake systematically the boarding out of patients as a type of treatment. This has been European practice in one form or another for several centuries. In Massachusetts responsibility for the system was divided for some time between the institution at Gardner and an assistant to the Commissioner. More recently it has been taken up by other institutions.

Conservatism is not only natural to those who have seen schemes come and go, but is also commendable within bounds. It might be expected that the experience of many other countries, plus successful use of the system in this Commonwealth since 1885, would lead progressive administrators not only to place out a modest number of patients in families, but also to throw their influence in favor of such modifications of the system as would make it much more widely useful. It is generally recognized by those who have any experience that \$4.50 per week is too low a board rate in the State of Massachusetts. A certain number of patients can be placed out at this rate, but not nearly all those for whom that management would be most helpful.

Every institution should send suitable patients into family life. There is no one of these institutions that lacks some patient who cannot be cared for by relatives, but who could live with reasonable happiness and considerable comfort in the care of some family under supervision of the physicians and social workers of the institution.

IX. THE HOSPITALS.

Most activities of the hospitals have been discussed functionally in a previous section. It is intended here to make simply a brief characterization of the various hospitals, with a comment on some special characteristics.

Boston Psychopathic Hospital.

This institution stands near the Fenway, and overlooks it from many of the windows. The district, however, is residential, and the surroundings are not comparable to those of the larger institutions in the country. The building is modern and without fire risk.

The institution is one of the older reception hospitals for temporary observation and study, having been in use since 1912. Usually this function is allotted to municipalities, but in this instance the Commonwealth recognized a community need that was not being met elsewhere, and provided boldly and broadly for it. This is a psychiatric teaching center for two medical schools, and gives courses in psychology and sociology to many neighboring schools and colleges. It conducts an active out-patient department and serves as a consulting center for courts and private physicians. Its excellent library is much used. Indeed, its facilities are now inadequate to its program, and everywhere except in the wards it seems crowded.

There are not enough beds, not enough consulting rooms, not enough office space, and the laboratories are pitifully out of relation to the great amount of clinical work carried on here. Quarters for officers and employees are inadequate because of the changing and greatly increased demands since the institution was opened in 1912. Two small and well-planned units for reception purposes were devoted to other purposes as far back as the war period, and are still needed for special treatments and studies.

Much valuable research has been carried on here. Students of psychiatry from all sections of the country have sought staff appointments or fellowships in this hospital. A psychological division does a certain amount of routine work, particularly with children, and also carries on special studies.

Under present arrangements this institution does not train the younger staff members of the state hospital service in nearly the measure that was originally hoped. Only one hospital sends every new physician to Boston for a month. Means should be found to utilize the teaching possibilities of this hospital vastly more by the staff physicians of the other state institutions. Service to psychiatric interests throughout the nation should be continued, with greater emphasis on service to psychiatry in Massachusetts.

Most patients do not remain here long, but small groups are retained for treatment and a very few for teaching purposes. The intimate relation with the Harvard Medical School and several general hospitals is capitalized to provide accommodations elsewhere for neuropathological work and some of the more complicated laboratory procedures.

Clinical standards are excellent and the records and reports made are admirable. Patients receive as considerable individual attention as is probably feasible in such a turnover.

All nursing is organized under the principal of the school. Affiliates come from seven general hospitals. Attendants have a short course.

The prolonged bath is widely used during the daytime. Occupational therapy has a special problem in stirring the interest of patients who stay but a few days. Physical education is not well organized.

Studies on the treatment of syphilis of the central nervous system made here have been quoted throughout the country.

Boston State Hospital.

This is a clumsily distributed institution in the southwestern part of the city of Boston. It has functioned since 1839; the State took it over in 1908. Parts of the grounds are very attractive; others are still rough. Highways border the institution on three sides and cut through it, and houses overlook most of its property. No effort has been made to obtain privacy through planting suitable hedgerows.

The buildings are of various styles and types. The earliest ones are of frame and stucco, and rather easily damaged. Those of another period have been protected against fire by sprinklers, and more recent ones are of brick and concrete. The appearance of the buildings is generally attractive. The service units are good, though shops are not large enough. Farming has recently been discontinued and the barns consigned to storage purposes.

At the time of the survey, many changes had recently been made in the personnel. The assistant superintendent was acting as steward. The lack of experience among employees was in contrast to usual standards in Massachusetts. Medical students are not at present assigned to this hospital.

The Institute is an elaborate building staffed by a very able group of persons engaged in research. It is also a teaching

point for the hospital staff, and conferences are held there weekly. Private funds largely finance it.

The clinic building is used for reception purposes. It was not originally designed to care for disturbed patients. This is a very well-equipped building with hydrotherapeutic and physiotherapeutic apparatus and personnel. The medical library is located there, with 1,174 volumes.

Cases requiring major surgery are sent to a general hospital near by. The tuberculosis building is well designed for its purpose.

A night medical officer remains up till morning and goes through all wards.

Nursing is organized in a unitary system. The ratio is 1 nurse or attendant to each 5.4 patients. This is by all odds the best ratio in the State of Massachusetts, and reflects credit on a former superintendent who successfully insisted that the needs of his patients required this number of nurses and attendants. Graduate nurses usually remain in the hospital but a short time, it is stated, under present practices. A two-year course in nursing has been given. This will be discontinued and affiliate pupils received.

Physical education is carried on actively. An art instructor works on a volunteer basis. The patients' library contains 800 volumes.

One cafeteria is a makeshift and its service is not satisfactory. Another is well equipped, though poorly laid out. Service of the disturbed, either in their ward dining rooms or their rooms, is good.

Danvers State Hospital.

On the top of Hathorne hill in the town of Danvers stands this imposing castle of mercy. The approach is pleasant and not too steep. On all sides one can look across rolling countryside for miles. The Middleton Colony is on lower sloping land only a mile and a half away. The district contains a population of 2,312,500.

The main building, a sturdy structure of brick and beam, has been given modern fireproof stair wells in most sections so that the fire peril is much lessened. Some other buildings are of frame construction.

Three colleges send students of sociology here for clinical teaching.

The medical library contains 500 volumes in charge of an untrained but attentive person.

The school of nursing teaches women only; it is a three-year course. Affiliate students come from four hospitals. Though men are not trained in this school, an affiliate man has been received. Students in the home school are given no experience on men's wards.

The reception service is badly placed and does not assure the new patient against observation of and by the older patients. Isolation of tuberculosis cases is not complete, since the special pavilion is not equipped for the custody of disturbed patients.

The physiotherapeutic apparatus is actively used. The occupational therapy shop is inadequate. Physical education has the attention of two employees. Singing is the only extensive use of musical therapy. The patients' library contains 2,000 books.

A large and pleasant dining room for patients has been recently put into service. Cafeteria service is used.

Foxborough State Hospital.

This institution was developed during several years on a definite plan by one of the ablest builders among American hospital psychiatrists. It was planned with careful detail to accommodate 1,000 patients and the necessary staff. It is an admirable example of an institution of the block type with connecting corridors, these corridors being usually two stories and basement in height, and serving section by section as sitting rooms for the adjacent wards. A few old buildings were included in the L-shaped layout and were integrated with the new ones.

Policies having changed, the institution has now been increased in size, and several functions have broken down and required replacement when facilities became overloaded. This is the usual history of American mental hospitals.

A restricted site on rolling land in eastern Massachusetts shelters the hospital. Most of the buildings are on a level tract, but the new tuberculosis unit is at a distinctly higher level and connected with the rest of the group by a tunnel. The institution owns 385 acres. The farm, being distant about two miles from the main hospital, has a colony building for workers. Obviously, this institution should not be expanded.

Consultants are called occasionally from Boston. The laboratory work of this hospital has equalled the best standards of the state service.

A two-year course in nursing is given, and both sexes are accepted as students. The instruction is given largely by the principal and assistant principal of the school of nursing, but their administrative authority reaches to only one of the male wards.

The large dining room of the institution has service from insulated carts which bring the food to the tables from the near-by kitchen. These carts are falling into disrepair and the present system will be changed to cafeteria service. Fifty to sixty special diets daily are prepared in addition to what is prescribed for the patients in the tuberculosis pavilion.

A large part of therapeutic occupation is carried out in the wards. The occupational therapist is also responsible for all recreation. Physical education has had but little attention. There is an orchestra of employees.

Besides three social workers there are two students. After-care is said to be well done, and two workers are in the field all the while. Pre-parole investigations are made.

Gardner State Hospital.

This institution was established with a special purpose in view, — to take idle but able-bodied persons with chronic illness from the various hospitals where they had been received and studied, and to give them simple dwellings in the country under the immediate care of mechanics and house mothers, but also under the expert supervision of the resident physicians. It was intended to scatter the patients about in "numerous small separate farmsteads and industrial groups, each complete in its home equipment and interest." This plan was pursued until 1912, since when the tendency has been toward the construction of fireproof buildings of larger size than those in the original scheme.

In 1915 this hospital was authorized to receive new patients, and in 1924 the building for the physically ill was developed and a reception service organized, since when the institution has done general district work. There still remain a considerable number of patients transferred from other institutions in accordance with the original plan.

The time has now come when another trend observable in hospital population all over the land is interfering with the original purpose of this institution. Patients long in the hospital are growing old, and a larger number of elderly people are included among the patients newly admitted. Hence the

number of able-bodied is relatively smaller, and there are more who must be managed as invalids rather than as employment problems.

The hospital is situated in a pleasant hilly district, and its buildings extend more than a mile from end to end of the plot. There is considerable variation in the size of the housing units, and no small ones have been built for many years. Indeed, three have been condemned. The land is of the type usually found on abandoned farms. This terrain was deliberately chosen, and its choice seems well justified; for after many years of rehabilitation the fields have proved to be fertile.

The superintendent and trustees have urged that more buildings of simple construction be added to the present layout. This has met official resistance, probably because of the difficulty in justifying such a policy in case a disastrous fire were to occur. Perhaps a compromise may be reached through the use of some type of construction similar to the prefabricated house. Means should be found to expand this institution somewhat in accordance with the vision of those who brought about its founding.

Whatever may be done about the original plan, there is need of some additional construction of a permanent type. A reception building is needed, and either a new treatment building or additions to the one now existing. There is need, also, of construction for the housing of personnel and officers.

This hospital has specialized, also, on the placing of patients in the community. For many years less interest in the boarding-out system was felt in other units of the state service. The amount allowed for board is \$4.50 and is inadequate. A larger allowance seems likely, to permit placing many more patients out. This hospital is rivaled by only one in having the largest number under boarding care.

Grafton State Hospital.

This institution occupies 1,100 acres eight miles from the city of Worcester. The terrain is hilly, well-wooded land only partly developed, and promising to furnish outdoor occupation in subduing nature for years to come. Two hundred and ninety acres already are cultivated, and other stretches of peat or fertile loam have been marked for improvement within the next several years.

Until 1915 this was a colony of the Worcester institution and accepted only transfers, but for over twenty years it has

received new patients. The buildings for patients are scattered about the tract in four groups, three near enough to have a common heating plant. There is considerable liability to fire throughout the institution. Sprinkler systems have been installed at points of greatest danger, and other measures taken for protection against conflagration. Porches are infrequent, and some of them have been glazed and closed in.

The medical library has 500 volumes.

Male students of nursing from one Boston institution come here for three months' affiliation. There are no accommodations for women affiliates. Medical college seniors and summer student internes get service here, and clinics are given to other students of nursing and certain theological students.

A considerable number of tubs are available for the prolonged bath, and are used up to 10 o'clock at night. Physical education is little represented.

All the cooks are women. There are five kitchens, sixteen dining rooms for patients, five for employees, and one for the staff. Many pantries are crudely equipped, and little attention is paid to such niceties as warming plates.

The tuberculosis service is disappointing, and the wards designated for these patients lack desirable equipment. The most active cases are not in the tuberculosis wards but in the infirmaries.

There is one open building. Ground privileges are seldom given because two highways and a railroad intersect the tract.

A large number of the patients in this institution were received by transfer and have no friends that can be found. Efforts to locate relatives or friends have been made over the radio as far west as Wisconsin.

Medfield State Hospital.

This is a country hospital standing on a hilltop well above the highway and at a distance from any village. The hospital owns 630 acres, rents 100 and cultivates 260.

For eighteen years after its opening in 1896 patients were received here only by transfer. There are still in the hospital some 500 patients without known relatives. This situation decreases the number of visitors.

The original buildings are cottages of the Queen Anne type, arranged in a large rectangle. The attractiveness of this arrangement was seriously damaged by placing other buildings inside the quadrangle. Later buildings are at a suitable dis-

tance behind the original ones. Much reconstruction has been necessary to remove fire risks and otherwise bring the structures up to present-day requirements. The more recent buildings have more permanent elements.

The autopsy rate here is about 50 per cent. The medical library is inferior, except for its pathological division.

The school of nursing maintains a three-year course, for women only.

The receiving buildings unfortunately accommodate also many ill and old people. Occupational therapy is available only on the women's service, but the industrial department provides occupation for some of the men. Physical education is but little developed, being without leadership. The patients' library has over 1,000 books, all gifts.

The service in the main dining room is satisfactory except that all dishes are cold. Insulated carts bring hot food to the point of service. As in many places, no water is served with the meal. Service to disturbed women is especially good.

Three open buildings for each sex house over 400 patients, and 30 patients in other buildings have ground privileges.

Metropolitan State Hospital.

This is the newest institution in the State. It is located in the town of Waltham, the buildings standing mostly on rocky hillsides, and patches of cured peat land in the bottoms are saved for cultivation. Only 383 acres are owned.

The metropolitan district includes three counties. This hospital has received patients from this district, but only through transfer from other institutions. The population is therefore almost entirely made up of patients with prolonged mental disorders, since recoverable cases among early admissions have already returned to their homes, and relatively few recoverable cases are admitted at present.

A receiving building is to be added to the plant, and direct admissions will then be accepted.

The patients' buildings are in two groups. One is a series of three-story blocks connected by broad corridors that serve not only for passage but also as sitting-rooms. These corridors go around three sides of a quadrangle, and the dining room and some accompanying structures fill in the fourth side. The buildings are carefully designed in many regards, but it must be said that their appearance is not altogether cheerful. Certain supposed economies in construction have resulted

poorly, since storms drive through the brick. The buildings are entirely fire-resistant. Porches are a usual feature of the wards and are adequate in size. These blocks have but few single rooms.

A large building consisting of center and several wings is called the medical building. This is constructed along different lines, with emphasis on facilities for the treatment of those with physical illnesses. In this building are eight dining rooms, whereas the continued treatment group sends all but one ward to the congregate cafeteria.

The installations in this institution are generally excellent. The laboratory and morgue are in a separate building, where study and teaching can easily be carried on. Autopsies reach 68 per cent of the deaths. The course given to assistant physicians from all over the State during the last few years centers in this hospital.

Five members of the medical staff have teaching appointments in local medical schools. Research is under way.

The attendants' training course differs from many in that lectures and demonstrations run through the year.

The hospital is well supplied with tubs arranged for the prolonged bath, but with its present population these are seldom used. Physical education is carried on by one instructress. The patients' library contains 5,000 books.

Over 225 patients have ground privileges, and there are four open wards.

Northampton State Hospital.

This institution stands at the top of a beautiful, gently sloping hill. The original building, in use since 1858, is a three-story and basement Kirkbride style of structure with a spacious entrance hall and impressive staircase. The farm buildings are at present too near the wards; but in architecture all these structures are attractive and were apparently made of the best materials of their day. Across a highway and near the edge of the hill is a group of recent structures consisting of four wings running back from a transverse front. These are good fire-resistant buildings, though not so pleasant as would be detached structures.

The amusement hall is attractive but has been outgrown.

Plumbing, even in reconstructed water sections, is not everywhere adequate. In one ward the ratio of toilet seats to patients is 1:32.

The medical library contains about 500 volumes. Though long the residence of Dr. Pliny Earle, this institution has no copies of the Journal of Psychiatry prior to three years ago; distressing destruction of the older magazines has occurred.

A two-year school of nursing is maintained for students of both sexes. Training of attendants is not attempted.

There is no separate reception service, and the new patient goes at once into an infirmary. Physiotherapy is not much developed. There is no gymnasium, but a recreational director is in charge of physical education on the lawn in suitable weather. The patients' library contains 2,500 books.

Certain exercise yards might be somewhat attractive, but too many patients are required to use them. The disturbed wards for women are very noisy because the ceilings have not been treated with sound-deadening material. Cases requiring major surgery are sent to a general hospital near by.

There is a fine new kitchen building and four large new cafeterias.

Ground privileges are granted to 200 patients, and about 120 have the privilege of going to town.

Taunton State Hospital.

This institution serves the southeastern section of the State, including Cape Cod. The land is slightly rolling, well wooded, and, when cultivated, is adequately fertile. Four hundred and sixty-seven acres are owned. There is an old plant, attractive in many ways but requiring reconstruction, and a quite new plant housing the physically sick and the new patients. There are also some service units rendered inadequate by increasing the size of the institution; for instance, the laundry and the dairy barn.

The autopsy rate here is 41.6 per cent. The pathologist has charge of the medical library of 1,100 volumes, which includes the Army Library Index and the Index Medicus.

Insulin therapy and prolonged narcosis are not under use. Metrazol therapy is carried actively.

The school of nursing accepts girls only. It gives a three-year course, the second year being spent in a general hospital. Eighteen or twenty affiliate pupil nurses also are at all times under training here.

The prolonged bath is used twenty-four hours a day for women and twenty hours for men. No seclusion is employed,

and the only type of restraint is an ordinary sheet with a clove hitch. The occupational therapy program includes classes in eight wards of each sex. Physical education is provided for women only. The excellent patients' library contains 7,000 volumes and has adequate annual replacements.

The main dining room has cafeteria service. In this room every care is taken to see that patients have plenty of time to make their choice, and no less than three main dishes are offered.

Two to three hundred patients have ground privileges.

Westborough State Hospital.

The original plant was built for a reform school and was converted to hospital use in 1884. It is pleasantly situated on sloping land near a lake. The old buildings are decidedly inflammable. Later additions were of factory construction, and the colony houses are frame buildings, but the most recent structures are of steel and concrete. Various suitable measures have been taken for fire protection.

Plumbing has been largely replaced; the poorest ratio of toilets to patients is 1:22. Electric refrigeration is used throughout the institution and storage of ice has been abandoned.

Adequate examining rooms are available on the different services, but no physician has his office close to his patients. The medical library is not strong.

The principal of the training school is officially responsible for all nursing, but gives by far the most of her time to the women's service. The school of nursing maintains a three-year course.

This hospital uses the prolonged bath by day and by night much more freely than do most institutions. There are four batteries of tubs, and a special point is made of assuring freedom of movement in the bath. Physical education is undeveloped. The patients' library numbers 3,500 volumes.

The patients' cafeteria is a new structure. There are 15 other dining rooms for patients in various parts of the grounds, and 5 for employees. Four hundred and thirty patients have ground privileges, and there are 7 open wards.

Worcester State Hospital.

* This institution has two divisions. The older is the smaller and is now called the Summer Street Branch. It is the original hospital of the State, opened in 1832. It now houses a few hundred patients of the continued treatment type. The main hospital is on the outskirts of the city; it is a building of modified Kirkbride type with additions and extensions. There are several accessory buildings, detached from the main structure.

The organization is very active. There are 16 medical consultants, a dentist, a physiologist and a physical educator. Besides the usual medical staff there is a research service whose director comes from Boston several times a week. Six other physicians and several other specialists make up the staff of the research service. There is a medical and surgical service whose residents are specially but not psychiatrically trained. The out-patient department carries an excellent child guidance clinic in the city. This hospital has for some time had both an assistant superintendent and a clinical director. It is a great training and teaching center.

The ratio of physicians to patients, calculated exclusive of administrators and special research physicians, is 1:181. Among all these physicians great variety of training is found, including much in neurology and some in psychoanalysis.

The medical library contains some 2,700 books and 700 bound volumes of periodicals. It is in charge of an erudite medical librarian.

Training of undergraduate nurses is confined to affiliates from three schools, each of whom spends three months here. A postgraduate course also is given. The new attendant gets a course of 44 hours. The nursing service is united under the superintendent of nurses.

A variety of treatments, chemical, hydiatic and psychological, is always in progress. The therapies discussed elsewhere in this report are all actively employed except physical education, in which there is no instructor. Elaborate central bathing facilities have been developed, and most of the bathing in the separate wards has been abolished. The patients' library is in charge of the medical librarian. It numbers over 2,400 books and 50 current magazines.

Not only are there four psychologists on the staff, but also two psychological internes and as many as four students.

Besides the general kitchen there are two diet kitchens. There is a large general dining room, attractive in style, and with an efficient cafeteria service. There is also a small cafeteria for disturbed patients of each sex.

Accommodations for tuberculosis cases are not entirely satisfactory.

There are six open wards besides two colony buildings.

X. INSANE CRIMINALS.

The policy of the Commonwealth is to identify as soon as possible among its lawbreakers those whose mental state is disordered. The Briggs Law, so called, requires psychiatric examinations of prisoners who have committed graver offences, and of all prisoners whose records indicate an inclination to repeat their offences. Suitable arrangements have been made to bring these about. The state hospital staffs make many of the prescribed examinations.

Offenders whose mental state is considered abnormal are not to be brought to trial till recovered. These and others who have been found while serving sentence to be mentally ill are placed under a special commitment as insane and turned over to the Department of Correction for treatment, in case the offender is of the male sex. Women of similar types are sent to one or another of the civil state hospitals.

Permissive legislation has been passed to enable the Department of Mental Health to build for these patients and assume their care.

Another special group are the feeble-minded offenders, or defective delinquents. They also are committed to the Department of Correction. At present their management is not an issue, since the Legislature is not proposing their transfer to the other department.

Bridgewater State Hospital.

Administratively this institution is a branch of the State Farm, where prisoners of ordinary intellectual standards and defective delinquents are under custody, as well as the mentally ill. The institution dates from 1888. During the survey it housed 891 men; no women are treated here.

A lay superintendent has charge of the whole group. The State Hospital itself has a medical superintendent and three assistants. These and similar details are presented in this

section because this hospital is not in the Department of Mental Health, and therefore has not been discussed in previous chapters. The Department of Mental Health has only the responsibility of inspecting and making recommendations. This has been done, it is said, about once a year.

On a slightly elevated plateau in eastern Massachusetts, five miles from the town of Bridgewater, this institution is located. The plant is on the whole unattractive. Some improvement might be made by decoration in gayer colors, but the buildings for the most part have a somber appearance and the architects have apparently been more esthetically influenced by penitentiary standards than by hospital style. The buildings are of two and three stories, with a large number of cells and considerable dormitory space. Sitting rooms, as a rule, are adequate, but where the more deteriorated patients exercise, still more space would be advantageous.

Some of the buildings are now old. It is the practice to scrub all floors of the institution daily and to take other strenuous measures to keep out vermin of every sort. Another reason for this vigorous treatment of floors is that little indoor work other than housekeeping is available for the patients. A 17-acre tract enclosed by a high wall is the truck garden for the institution. The farming is done by the mental patients.

There are 123 attendants, making a ratio of attendants to patients of 1:7.2. The institution employs no graduate nurse.

Little restraint is used here, but seclusion is freely employed, especially at night. As usual in a population of this sort there are some desperate souls who might take advantage of any opportunity to injure a fellow patient or an employee. For the most part, the problems of care and treatment are not different from those found in the civil state hospital. There has long been criticism of the régime here. It does not appear to be unduly repressive, but the lack of planned activity for many of the patients is regrettable.

A considerable number of admissions come from jails on a thirty-five day commitment for observation. This procedure works less well here than in the civil state hospitals. No history may be available from the jail, and the mental capacity and responsibility of the patient may not be determinable within that time.

The superintendent is strongly of the opinion that the Department of Mental Health should build for these patients. He is confident that the present practice of paying a larger

wage to ward employees here than in the civil institutions should be continued, and that it will not be difficult to make a case for it.

XI. TREATMENT OF CONVULSIVE DISORDERS.

Convulsive disorders, a large part of which are usually included under the term "epilepsy," are prevalent in every community. No census of cases in this country has ever been taken. When war comes on and a draft is instituted, the number of citizens who report having such disorders is surprising to one who is unfamiliar with the subject. This indicates merely that in many cases the convulsions are few or occur at a time of day or night when they do not interfere with social and business activities. Hence, only a fraction of the known cases require hospital care.

In 1898, after due preparation, Massachusetts opened a hospital for epileptics. Humanitarian and social principles determined the admission policy from the beginning. The first patients were transfers from the state hospitals. When patients were received direct from the community, preference was given to those who were the greatest burdens on their families or their municipalities. Accordingly, the patients received have very largely been the most thoroughly established cases.

Under such circumstances special measures must be taken in order to get patients who have recently developed convulsive disorders to come to the hospital for study. The well-to-do often send their members to private hospitals for this purpose. In Massachusetts the Monson State Hospital offers an arrangement by which the indigent epileptic may come into the hospital for two weeks to receive a careful examination and appropriate advice. This opportunity was taken advantage of in 78 cases during the last year, mostly from the western part of the State. Most early cases can be and are treated in an office or a clinic at home, but such a period of hospital study may be very important for them.

The admission policy of the State is to accept for longer care those patients that present the greatest difficulties to their families and their neighborhoods. In general it may be said that there are three ways of entering the hospital:

1. The patient may come of his own desire and enter as a voluntary admission. The unfortunate *obiter dictum* in a case of mental disorder some years ago that has resulted in so much restriction of vol-

untary admissions to the mental hospitals has not exercised the same devastating effect on admissions to the institution for epileptics.

2. A patient may be received under a commitment for mental disease. This makes simple the transfer of suitable patients from the other state hospitals. It also makes easy the admission of epileptics who in the course of their disorder have developed a definite mental illness in the community.

3. There is a special law under which epileptics who should not be at large can be committed to the institution without any statement regarding their sanity. This wise provision takes care of those unfortunates who are not reasonable enough to enter the hospital of their own volition.

An institution for the care and treatment of epileptics has some points in common with the hospital for mental disorders. There must be provision at all times for a few patients who are so disturbed that they need special nursing and other special measures to prevent injury to themselves and others. There must also be a variety of occupations to prevent, as far as possible, the distressing deterioration of interest that characterizes so many of these cases. The institution also resembles the training school for defectives. Many epileptics are defective in intellect. Their schooling must be carried as far as possible, but they must be given, also, a special amount of training in types of work that are suited to their disorder and to their mental capacity, and that will assure them of hygienic life. These institutions accordingly have a school that carries patients through elementary work, and since some epileptics are as bright as children in the community, special provision is often made for this small group to carry them into the higher school grades. There is much vocational training, especially outdoor employment. Some parts of the institution will resemble an infirmary or a hospital for incurable diseases; for some epileptics are cripples and others deteriorate into a torpid state in which they must be cared for like young children.

All this the Commonwealth has provided in the hospital at Monson.

Monson State Hospital.

Among some hills across a river from the town of Palmer is a tract of 661 acres supplemented by 15 acres that are rented. On slopes stand groups of buildings, conveniently separated by watercourses running down to the valley. One group of buildings is for children of both sexes; another, houses many

boys and men; the third, provides for all others. Near the center of the institution is the administration building and across the road is the reception building. The construction represents many periods. As might be expected, the oldest buildings are distinct fire risks, whereas the newest ones cause no concern on this score. A program fairly well agreed upon provides the necessary reconstruction to assure safety, the cost to be spread over several years.

When visited in summer the institution had a census of 1,506, but during the school year some 70 more patients come in for training. The school carries as many patients as possible through the fifth grade.

An active program of treatment and study has always been practiced here. Indeed, this hospital staff has supplied leadership in its field, and its published reports are accorded great respect. The neurological service, the pathological department and the school all receive due attention. Medical students come all the way from Boston for clinics. There are two internes on the staff continuously. Psychological service is supplied. The records contain much valuable material; as a rule, no summary is available for the reader, but the detailed findings can easily be located. Nursing personnel is approximately 1 to each 6 patients. This reflects the very great needs of the helpless and crippled groups. There are positions for 27 graduate nurses.

Problems of feeding have led to the recent building of a new kitchen with adjacent dining room. The service of food varies in accordance with the needs of the particular group of patients, and those who can make use of it have quite as comfortable a dining arrangement here as would be likely at home. Some buildings have poor dining rooms in basements.

Discipline is in the hands of the physicians. Transfer, restriction of privileges, and separation from other patients are the means ordinarily used. Restraint is used only in special conditions, such as manipulative vomiting, and not as a matter of discipline. It is also employed occasionally in epileptic furor. Seclusion is occasionally used. About 10 patients are locked in their rooms at night, apparently for good medical reasons.

On a day when the population was 1,501, two thirds of the patients were idle, somewhat less than a third were incontinent, and one fifteenth were cared for in bed. This gives a hint of the problems of care for this type of patient. It also

shows the need for constant study into every means available for stimulating the interest of the large deteriorated group. Occupational therapy here reaches, perhaps, 150 patients, or 10 per cent. Hospital industries occupy 350. Sports receive some attention, but could be further developed. The patients' library numbers 1,400 volumes and is well supported.

The chief emphasis of the activities of the two social workers is on getting histories and assisting in an out-patient clinic.

About 500 patients, or a third of the population, have ground privileges. There are usually 200 at home on visit.

XII. THE TRAINING AND CARE OF MENTAL DEFECTIVES.

Massachusetts was the first State to undertake institutional management of the mental defective, and opened its school in 1848. As time went on the demands of the community increased. The original school developed a colony at Templeton in the northern part of the State. Other schools were added at Wrentham and Belchertown. In structure and in organization these show the continuity of planning and the inspiration of the great minds of Howe, Seguin, Fernald, Wallace and others.

These schools were established primarily to serve as training and educational centers for younger defectives. It was hoped that children of pre-school age would go to the institution, be developed there, and return to society under supervision. At the same time the lower-grade children would receive special hospital care and habit-training where training was possible.

The state policy with regard to mental defectives is challenged by the existence of a huge waiting list. Two thousand names are recorded at one school, 750 at another, 600 at the third. Selections are made from these lists whenever vacancies occur, but not by priority. The new admission must be chosen with a view to his fitting into the vacancy that has occurred. It is hard to see how public needs and demands can be satisfactorily met by this system; plainly, another institution will be required.

Another development has interfered with the original plan. There is an increasing inclination in society to consider that wrongdoers should be treated more on the basis of their endowment than on the basis of their delinquency. More and more feeble-minded persons who have committed offences are sent to these schools for defectives. This forces the insti-

tution into a closer approximation to correctional institutions, where older incorrigibles are collected. Such a situation affects the amount of freedom that can be given to any of the patients; it affects the program, and it affects the atmosphere of the school. These difficulties have been, for the most part, satisfactorily met in the institutions.

Sound construction has been the rule in these schools as in the mental hospitals. Efforts have been made to keep construction costs lower for able-bodied children than for the sick or crippled. This effort is commendable, but has sometimes made elements easier to destroy and quicker to disintegrate.

Medical care in these institutions is excellent. The resident staff do most of what is necessary and consultants are on call. Each institution has a good hospital and some graduate nurses to look after the physically ill. The usual preventive inoculations are given.

The incidence of tuberculosis appears to be low in these schools.

Clinical records in these institutions are very illuminating in the types and quantity of material they carry. There is rarely on file a summary review of all the information obtained.

Most of the housing in these schools is in cottages presided over by a matron. Sometimes a group of men are under the direction of a man.

Food is simple, good and abundant. Good appetites are the rule, but cripples and children of low-grade intellect have to be fed; this work is done by employees and older patients. Every house has its dining room.

Discipline is the responsibility of the ward physician. Discipline involves (1) posting the name; (2) deprivation of privileges; (3) rest in bed; or (4) seclusion.

The emphasis laid upon sense training for children of the lower class is very admirable. Many are able to go as far as fifth-grade work, and a few do even better in one or perhaps two subjects. Speech training is usually given as a concomitant of school work. Music is taught in several ways; considerable singing is done by groups and orchestras, and rhythmic bands are developed.

Industrial training is given in such subjects as woodwork, weaving, bookbinding, domestic science and the like. A large number of boys and men are employed on the farms.

Physical education is looked after satisfactorily. Perhaps in some of the schools it might be carried even further without profit.

There is an excellent program of amusements. Religious services are held regularly. The libraries are appropriate.

The Walter E. Fernald State School.

In 1848 the first institution for mental defectives in this country was opened in South Boston. Later it was moved to Waverley; and it now bears the name of one of its great superintendents. It is located in a pleasant, hilly district. Grading has been wisely done, so that the advantages of the hilltop are preserved for the most prominent buildings, and at the same time the beauty of the slopes and lowlands has not been destroyed. The institution comprises separate buildings of various styles designed to meet the needs of different groups. A relatively simple type of cottage is repeated several times to house the largest number; but those who are feeble and those who are very young have special accommodations. A good school building has been in use for some years, and there is a new assembly hall.

At Templeton, about seventy miles from the parent school, there is a colony for 310 boys. The land is rough, and the patients live the life of the woodsman in simple buildings, considerably overcrowded, with plenty of work and an atmosphere of accomplishment. It is stated that when one of these boys has occasion to return to the school because of misbehavior or illness, he is always very desirous of getting back to the colony.

By arrangement with the Metropolitan State Hospital patients in need of surgical treatment or of more than ordinary medical care are sent to that well-equipped hospital for the duration of their illness. Very few deaths occur at the school, only three in one year. More die at the Metropolitan State Hospital. This arrangement perhaps influences the organization of the school; there are but two graduate nurses here.

The pathologist is clinical director.

New patients are received in accordance with the type of vacancy existing in the school at the moment. There are some epileptics scattered through the institution, the institution for epileptics not having adequate capacity to care for them.

Each cottage has its dining room.

The cottages are mostly open, but when the children go out of doors they are supervised. Since a large number of girls have been sex delinquents in their communities, it is the policy of the school to give very close supervision to all their female patients. A few boys have ground privileges.

Ever since its founding this school has been the fountain of advice to many Massachusetts families about the management of feeble-minded members in their homes. An afternoon is set aside every week for these consultations. All the medical staff participates at different times in this clinic, and psychologists and social workers contribute their special knowledge.

The Wrentham State School.

This institution was planned on the basis of experience at Waverley, was erected according to plan, and, when expanded beyond the original plan, was not rendered inharmonious. The institution owns 625 acres of rolling land, mostly the sandy loam characteristic of eastern Massachusetts. The buildings are arranged about a large, level quadrangle. One notices no indication of confinement on the grounds, and the general impression is about the same as one would get in any children's village that had been expanded to an unusual size. A standard type of cottage was worked out and repeated several times. On the first floor and in the basement are day rooms, and sleeping quarters are on the first and second floors. Some one-story buildings for children and cripples have been added.

There are four farm cottages a half mile from the center. The medical staff includes an assistant superintendent, six assistants and a clinical director. One physician spends his time with the school clinic.

The laboratory is engaged in research investigation. Fifty per cent of deaths come to autopsy. X-ray equipment is good.

Belchertown State School.

This is the youngest of the three institutions for defectives, having begun operations in 1922. It receives patients who are two years old and over, from the western half of the State. During the survey it had a population of 1,311, including an overload of 5 per cent. It was originally planned to develop this school to a considerably larger size, and this scheme will probably be effected when the economic depression lifts.

Construction is good. As an economy measure the roofs were laid on beams and are not fire-resistant.

The provision made for these children may be described as adequate but economical. Beds in dormitories are rather close, and sitting rooms are a little too small, but a playroom in the basement of each cottage relieves the situation. Porches are small.

Plumbing is thoroughly adequate, but two details of installation are objectionable; shower heads have sometimes been placed over the middle of a toilet room, and there is no privacy in the toilets.

The school has eleven teachers. The schoolrooms wrap around a well-appointed assembly hall. There is also a good industrial building with shops of different kinds.

XIII. DISCUSSION AND RECOMMENDATIONS.

Any criticism of a fine medical organization performing sympathetically and intelligently a vast service to its commonwealth may seem superfluous. But this is not so. Massachusetts in most matters is not satisfied with the good, but only with the best. This has been the case with its organization for mental health activities, whose progress has been checked to a degree by the events of the last several years. It is believed that not only those whose daily work is with the mental patients, but also the body of intelligent public opinion, is in favor of every measure, great or small, that will put the Department in the forefront of such organizations anywhere in the world.

Accordingly, the following remarks and recommendations are submitted to the Special Commission on Mental Diseases. Theirs is not the responsibility or power to have these measures made effective, but they can speak for the people of the State, and what they say will be sympathetically heard by the Department of Mental Health.

If the State does not go forward it cannot maintain the standards already set up. The new Department can count on support if it goes ahead, but would fare ill if it should try to stand still.

Organization of Department.

Earnest discussion preceded the legislation of 1938 by which the present structure of the Department was set up. Perhaps no immediate change should be advocated, but a thorough

trial of this scheme should be had. The abolition of the associate commissionerships probably bore some relation to the fact that the old law placed on these men duties that they were not in a position to carry out, except in a routine and rather blind manner. There was, however, a virtue in the organization that should be imitated, but in better form and detail.

1. Probably the most effective organization would be a council on mental health. The councillors should be persons expert in various fields related to the work of the Department. A sanitarian, an engineer, a social welfare worker, a business man of large interests, a psychiatrist outside of official circles, an internist could be of much service to the mentally ill of Massachusetts if they were called together at stated intervals to discuss the problems of the institutions. Needless to say, they should not be burdened with any responsibility for signing pay rolls or contracts, or doing other routine matters about which they cannot possibly be informed.

2. More vigorous inspection of institutions should be maintained by the Department. This will include interviews by the inspector with all new patients. It will also include a better inspection of plant than has sometimes been afforded. The unhappy conditions that have grown up through the years have in some plants been corrected. Inspection will supply reminders to those in control of finances about things that need to be changed.

3. Official attention should be given to standards of treatment; for instance, in syphilis, tuberculosis and alcoholism there should be some unification of practice where the best methods are not now in use.

4. Another division in the Commissioner's office should correlate the institution clinics, the relations of the Department with the schools, and relations with adult education. The relation of the hospital clinics to elementary schools and high schools should be studied. Advising this division there should be a co-operative committee of educators, personnel officers and welfare executives. With the continuous activity of this committee, the subjects just mentioned can be taken out of the realm of the spasmodic and into the realm of structure and principle. The committee would be interested in the relations of mental hygiene with industry also.

5. In the organization of the Department there should be a division of research, co-ordinating the special studies made in all the institutions. This division should have an advisory body of men with interest in and knowledge of research, and to this body a report should be rendered every year on what is being studied and what has been learned. Research should be applied to all the activities of the hospitals. Not only should there be further study of physiological functions and chemical treatment, but a review of procedure, such

as, for instance, to determine how much can be accomplished by the nurse, what the special therapist can do, how much attention from a physician is important in various groups of cases.

6. The Department of Mental Health should be interested in the psychopathic departments of general hospitals, and should promote their establishment by local authorities in order that every resident of the State may have easy access to treatment for all stages and forms of mental illness. The influence of the Department, if exercised vigorously, could accomplish much in this direction.

7. In spite of occasional advocacy of a sort of totalitarian arrangement by which local institutional boards would be abolished, this Commonwealth has kept them in existence, with somewhat decreased power, to be sure, but with very considerable influence. Their services to the community and through the community to the patients is very great. The Department should cultivate not only the good will of board members, but also their activity in behalf of the hospitals that they represent.

8. It is believed that the fine traditions enjoyed by the Department for many years, in respect both to business and to professional activities, have suffered from the impact of political considerations. Speedy elimination of any selfish interests that remain will tend to restore public confidence in this important Department.

Statutes Relating to Admission.

The commitment law of Massachusetts is liberal, and, in the main useful, as it stands, but is susceptible to improvement so as to conform to the conditions and needs that are actually met in practice.

9. The idea of "treatment" should replace that of "commitment," which is an inheritance of the time when the insane were treated as disorderly characters and committed to jail. The term "insanity" should be replaced by "mental illness." The wiser judgment and authority of medical officials should be relied upon as implicitly as those of judges. A large proportion of patients suffering from mental illness would accept hospital treatment without protest. "Commitment" is associated with and in some places is patterned after criminal procedure. It is humiliating to patient and family, determines to a considerable extent the "stigma" attached to hospital treatment for mental illness, and is frequently resented more than hospital residence. The system occasions unnecessary expense, perpetuates an outworn and misleading conception of mental illness, and impedes the development of much-needed extension of facilities. In Massachusetts fears of "railroading" and malicious detention may be dismissed. Designing persons who wished to sequester any one improperly would never resort to one of the recognized mental hospitals, which are, as

a rule, freely accessible, and are inspected regularly by state medical officers.¹

Many years ago commitment was not required. In Maryland, Rhode Island and Delaware many patients are received in the mental hospital without recourse to the court. In New York certain types of cases may be admitted on the certificate of one physician. A court order is, indeed, necessary for the detention of some protesting patients, and access to the courts by the patient or by some one in his behalf is a fundamental right that cannot be denied. No one is more concerned in obtaining the protection of court authority than those who find it necessary to bring an objecting and perhaps menacing patient under treatment, and the hospital physician whose professional duty it is to protect the sick man and society and to furnish suitable treatment to an irrational person.¹

A chief justice of Massachusetts expounded this subject many years ago in the words: The right to restrain an insane person of his liberty is found in that great law of humanity which makes it necessary to confine those who, going at large, would be dangerous to themselves or others. . . . The question must, then, arise in each particular case . . . whether restraint is necessary for his restoration or will be conducive thereto. . . . The law relating to the mentally ill has been gradually amended in the direction of facilitating treatment. Its provisions, however, still contain too much that harks back to conceptions of "insanity," "commitment," "railroading," and relies on legal formalities and technicalities too much to permit the freer development of the facilities and practices that will extend treatment and preventive measures to mental illness in all its stages and phases in the community, and that are required for a widespread mental hygiene program.

10. The health officer should supplant the poor authorities as the one responsible for the mentally sick patient pending commitment. His request made on proper form should be sufficient basis for the reception of suitable cases and their detention in the hospital for twenty or thirty days. The question of suitability should be determined by the superintendent.

Specialization by Hospitals.

11. In a service so large as Massachusetts there is opportunity for specialization in various directions. It is, indeed, impossible for hospitals to expand exactly alike, since the interest and the spirit of two superintendents can seldom be identical. Specialization saves need of duplicating facilities for small groups needing the same treatment.

12. In this connection it should be pointed out that the original character of the institution at Gardner should be preserved. Let it be agreed that it is better for patients and for their relatives that

¹ Dr. William L. Russell, Memorandum, 1938.

each state hospital should be a receiving point. The district, however, from which Gardner receives should be made small, and emphasis should be laid, as in the early days of the institution, on the placing of patients in small groups where they can be encouraged in useful activity. If necessary, transfers of the physically infirm should be made to other institutions in order that this one shall not have so large a number of them as to defeat its primary purpose. It should be provided with any necessary facilities for those who are disturbed; from the disturbed group will come a constant stream of patients into the cottages, there to be absorbed among the workers.

13. There are many advantages in centralizing the treatment of tuberculosis. The unit at Foxborough might be expanded for this purpose, since the original plan of keeping the population of that institution at 1,000 has already been discarded. If some other point should be considered more desirable, the Foxborough pavilion should be converted to other uses.

14. Some hospital might well specialize on the treatment of voluntary patients. It would have a very happy effect on some groups in the community if it were known that even one hospital would welcome the applicant, provide suitable treatment without stigmatizing legal formalities, and thoroughly respect the patient's judgment. Since no hospital is small enough for such procedure, every hospital should encourage admissions of voluntary patients, and have some section in which they can feel comfortable.

15. Comment has been made on the difference in practice regarding nurse training. One hospital, for instance, has no accommodations for women, but specializes on giving affiliate instruction to a group of male student nurses. Perhaps this is the institution in which there should be developed an excellent school for male nurses. The need of trained men has been presented in paragraph No. 5.

16. Some institutions might well specialize in the care and treatment of elderly patients. To some extent this is done now at the State Infirmary, but without the same direction that would be given in an institution fully under the jurisdiction of the Department of Mental Health.

17. Various types of special treatment could and should be developed, and hospital administrators should be encouraged to develop and exploit any new and probably useful measures. This would in no way interfere with as high a standard of general care as is now maintained in any institution in the State.

Treatment.

18. The new patient should be received in a building so planned and furnished as to seem to him a homelike place.

19. The program of treatment for disturbed patients should be reviewed and further steps taken to reduce the number of those who spend the night behind a locked door.

20. Fundamental physiological activities should be insisted on. Patients should be gotten out of doors with much more regularity than now exists. Explanation of failure in this regard is sometimes based on alleged shortage of personnel; again, on conflict with the program of other activities; again, on lack of sufficient outer wraps or overshoes. Ventilation should have as much attention as proper bedding. The hair, the face and the feet should be given proper attention.

21. A matter that requires review is the efficacy of plans for occupying patients with useful work. There seem to be differences in the results of the efforts put out. Occupational therapy and hospital industry — whatever division is made of these activities — should be penetrated by consistent and skillful effort to have every patient employed at something useful if it is at all possible to do so. Some attendants have a special power of leadership in this field. If, for financial or other reasons, such persons have not taken a course in occupational therapy, it should still be possible to detail them to this work. There should be constant study of the organization to see that, aside from the trained therapist, other persons are so assigned — nurses or attendants — whose native capacity can be developed within the hospital. Such detailing of nursing personnel should not be at the expense of the regular nursing activities. Administrative ingenuity can certainly master this detail.

22. Physical education should be much expanded in the hospitals and perhaps to some extent in the schools. Its benefits to the physique and to the morale are about equal. Some institutions have asked for several years for the appointment of a director of physical education — without success. Such provision should promptly be made.

23. The very fine work that has been done by a few hospitals in maintaining a system of family care in the face of inadequate appropriations should be taken up with more vigor by other institutions.

24. The inebriate presents a social problem in every State in the country. Massachusetts in a previous period organized special measures for the alleviation of the situation created by the large number of persons in the community whose use of alcoholic beverages not only damages their own usefulness and acceptability but also creates perils for others. Perhaps the old measures would not meet the present situation and should not be revived. Certainly the best thought of the day should be applied to this matter, here as elsewhere. A start may be made by giving out-patient treatment to such persons in the clinics.

Personnel.

25. The training of personnel is fundamentally important. At several points in this report, mention has been made of the training of physicians and of nurses. Other groups of personnel also need training. There should be an annual review to see what has been accomplished in this field.

26. Schools of nursing should be strengthened. Most of these hospitals should continue to give full training for registration, with the assistance of a general hospital affiliation. These hospitals also should provide affiliations for a large number of general hospital training schools. The ordinary nurse on registry refuses to take mental cases, and it is the responsibility of psychiatric organizations to fill this need in the community. Added to this is the well-known fact that it is always difficult and usually impossible to get enough graduates of general hospital schools to fill even the posts for physical nursing in the mental hospitals. A nurse supervisor on the staff of the central office of the Department might do much to establish a uniform, effective system of training in the different hospitals, and take a hand in shaping nursing legislation and governmental administration of nursing education and practice.

27. Students of many disciplines should be encouraged to do part of their undergraduate work in the state hospitals. The experience of a few of these institutions shows that faculties welcome such an opportunity for field work. One may mention students of theology, students of medical technology, students of psychology, student librarians. Students of social work should do at least part of their field work in a mental hospital. The graduates of other schools of social service that do not follow this plan receive too little psychiatric teaching, and have been found unsympathetic to the needs of the state hospitals. A field thus far very little cultivated lies in the law schools. Those who are going to make the laws and perhaps administer the law should learn during their student days more about the human being, so that laws may be reasonable.

28. Commutation of subsistence and quarters should be provided liberally for married employees and employees of long service, rather than to require them to live in.

29. It is not proposed that all salaries and wages be increased, but it is desirable that at an early time the wages of nurses and attendants shall be added to. Whatever increases the respect in which these positions are held reduces wasteful overturn of personnel and makes for better care of the patients.

Community Activities.

An ideal set for the institutions of Massachusetts some years ago was that each should be the center of all mental hygiene activities in its district. Much has been done to make this plan a reality. It should always be held in mind.

30. The work of the clinics should be reviewed. Perhaps there has been somewhat less advance in their functioning than would be the case if they were not so much better than one finds in many other parts of the country. This is the penalty often paid by a progressive organization that institutes something new. The situation should

be reviewed with a view to determining whether clinic physicians are given the best type of training before undertaking their work; whether they are given the most helpful supervision during the period of their clinic service; whether they all are expected to operate in the same way in spite of the fact that rural and urban activities must actually be different. It seems very probable that a clinic will not do good work if a social worker is available only a half day a week. This and other matters require thought and study. Perhaps the decisions of school clinics are under the law too automatic, so that both parents and educators at times dislike to send their children to the clinic. On the other hand, there is a widespread demand from social agencies and individuals for broader service from clinics. It is probable that some clinics should carry education and research much farther than others. Training of clinic physicians at the Boston Psychopathic Hospital should be considered.

31. Social service should be strengthened. Perhaps some of the more active hospitals should even reach the ratio obtained in a Michigan institution, where there is a social worker to every 200 of the resident population. No excessive case load is an economy.

Institutions.

32. No further increases in size above about 1,500 beds should be made except in so far as some particular function requires a special structure.

33. A review of the building program should be held, with a view to determining if more one-story structures cannot be erected with reasonable economy, especially to provide for the aged and feeble.

34. A hospital of 1,500 beds, designed to give the most suitable care and treatment to the insane criminals now in Bridgewater, should be erected, and not in the neighborhood of a prison. Additional patients whose trend of activity entitles them to the same close oversight may be sent there from other hospitals.

35. To the Boston Psychopathic Hospital a wing should be added with the following facilities: At least two units for adults containing 15 to 20 beds, and at least one unit for children; pathological laboratories of ample size; a record room; special interviewing and conference rooms; additional quarters for personnel; rooms for physicians.

36. A bridge or tunnel is needed between the different groups of buildings at the Boston State Hospital that will relieve the present peril in crossing the highway. Such treatment of the grounds should be sought as will save the patients from the present unsatisfactory observation by neighbors on all sides.

37. Several more hospitals should have a well-planned reception service. These should not be so large that they cannot be homelike. Danvers, Northampton and Worcester are cases in point. These institutions have a considerable admission rate and should be able to receive their new patients in a building separate from the rest of the

hospital. Many patients should be kept under intensive treatment up to two or even three years.

38. Mentally sick children appear now and then in homes and institutions for children and create much greater difficulties than their number would indicate. A unit for such children should be developed at one of the hospitals.

39. The great waiting list of mental defectives should not be permitted to stand. The Commonwealth should either reject an applicant or make provision for him. Another institution should be planned.

40. Arrangements should be made to relieve the state hospitals of defectives without psychosis.

41. When a new institution for defectives is developed, it might do well to specialize on those patients whose inclination or training has been anti-social. Since such persons are found in all the training schools, there would certainly be some in the new one, and if a larger number of them were provided for it would enable the older institutions to transfer such cases and to resume the freer atmosphere that originally existed. Certainly some of the present structures in which such youth are housed are not convenient for their care, and cause an unnecessary measure of concern to those responsible for the patients.

42. The service of food should be reviewed. In cafeterias service should be revised if meals are not served hot, if water as well as other fluids is not easily available, if there is no choice of main dish, if fluids are slopped over the counter and the trays, if more than four minutes are used to pass from the door of the dining room past the counters and to one's seat. In other dining rooms the best standards should be sought.

43. Antiquated equipment should be replaced. Any activity that is worth carrying on in a hospital is deserving of equipment and supplies that will make it function well.

44. Fire hazards still exist. They should be surveyed and speedily eliminated.

Medical Staffs.

45. The opportunity of competition for promotion on the part of physicians in the same grade in all the institutions, rather than confining promotion in each hospital to its own staff, will combat the tendency of a large service to discourage some of the keener minds and lead them to seek opportunities outside the hospitals. Non-competitive examinations should be instituted for promotions from the lower to higher grades in the state service. Competitive examinations should be required of candidates for first assistant superintendent, clinical director and superintendent.

46. Since many physicians take up hospital psychiatry as a career, the Department should make it possible for such men to have experience on the staffs of three types of institutions: hospitals for mental disorders, hospitals for epileptics, and schools for mental defectives.

47. Every hospital organization should be a teaching body. New physicians come to the institution with little knowledge of psychiatry, and the privilege of training these physicians in their work and in assuring their knowledge of this branch of medicine should be a serious concern of the older members of the staff. Similarly, the training of every employee of the institution to base all his activities on what will be in the long run most helpful to the patients is one of the most important responsibilities of the medical staff.

48. Courses should be arranged by which physicians in the state service keep fresh the knowledge they already have, and learn the newer methods and practices.

49. The practice of receiving affiliate internes from general hospitals should be much extended. The state service has a great deal to offer these young physicians if its facilities are properly organized for this purpose. The experience of two of the medical schools in Boston of sending their undergraduates to the hospitals has laid the groundwork for this greater service, which, indeed, will reach many young physicians from medical schools outside of Massachusetts who have had no opportunity to learn psychiatry at the bedside during their undergraduate course, but have come to Massachusetts for their internships.

50. Clinical records should be still further improved in clarity and conciseness.

51. The system of frequent recommitment of the new patient creates an unprogressive atmosphere in the medical staff conference. Its time should be devoted to clinical issues, the nature of the mental disorder, and the treatment to be attempted.

52. The weaker medical libraries should be steadily enlarged.

53. The offices of physicians should be near the patients. The present concentration of medical desks in several of the institutions should be broken up and more separate offices provided.

The surveyors tender their grateful appreciation to officers and employees in the Department and in the many institutions for their unfailing courtesy and patience in giving the information that was asked in connection with this study.

APPENDIX 12.

PROBLEM OF PERSONNEL.

The thirteen hospitals and three schools within the Department of Mental Health had quota positions for employees as of December 1, 1938, totaling 6,976.¹ To this should be added 207 non-quota workers, consisting chiefly of students attached for training purposes.

Prior to the passage of the so-called Forty-eight Hour Law,² each institution had attempted to house its entire personnel with the exception of a relatively small maintenance group consisting of engineers, carpenters, painters, etc. (non-maintenance quota¹). This policy resulted in a considerable capital investment by the Commonwealth in buildings devoted solely or partly to employee quarters.

At the present time employees are quartered in nurses homes providing large numbers of single or double rooms, in cottages, in remodeled buildings, in portions of buildings devoted to administration, in some instances in ward buildings and basement sections, etc. Furthermore, there has developed in the course of time some crowding of employees, due, at least in part, to the fact that additions of positions to pay rolls could not immediately be matched by the addition of a like number of adequate quarters, and in part to the addition of students from schools affiliated for teaching purposes. The exact picture of such crowding and of rooms not entirely adequate or satisfactory cannot be expressed in figures available at present.

It is recommended that the Department of Mental Health conduct a careful survey of the employee housing situation in each of the institutions under its jurisdiction, and, acting upon information so obtained, take steps to eliminate undesirable quarters (such as basement or ward rooms) and undue crowding.

¹ See Table 1, "Institution Personnel."

² Acts of 1935, chapter 444, approved July 25, 1935.

This thought naturally leads to a consideration of outside maintenance policies for employees. The 1935 act, previously referred to, brought into the service of the hospitals and schools within a few weeks' time over 1,000 individuals. Local facilities being inadequate to house the greater number of them, a restricted number were allowed to reside off the grounds and receive money in lieu of maintenance at the institution. This number allowed to reside outside was conditioned, in each instance, by the institution's ability to provide quarters.

TABLE 1. — *Institution Personnel.*¹

INSTITUTION.	Quota Positions.	Non-Quota Employees Furnished Maintenance.	Quota Employees Furnished Maintenance.	Quota Employees Furnished no Maintenance.	Quota Employees, Money in Lieu of Part Maintenance.
<i>Hospitals.</i>					
Psychopathic . . .	156	24	102	16	38
Boston State . . .	738	19	598	35	105
Danvers . . .	550	20	344	35	171
Foxborough . . .	332	3	206	22	104
Gardner . . .	334	—	268	19	47
Grafton . . .	415	2	287	35	93
Medfield . . .	477	—	343	42	92
Metropolitan . . .	415	6	232	26	157
Northampton . . .	474	—	373	32	19
Taunton . . .	442	51	382	31	29
Westborough . . .	424	—	373	32	19
Worcester . . .	632	82	445	39	148
Monson . . .	419	—	300	33	86
<i>Schools.</i>					
Belchertown . . .	298	—	220	24	54
W. E. Fernald . . .	465	—	413	27	25
Wrentham . . .	405	—	299	22	84
Totals . . .	6,976	207	5,172	468	1,336

¹ Data derived from Department of Mental Health records.

Compensation in lieu of maintenance was computed at the following yearly rates: in lieu of room, \$120; in lieu of one meal, \$80; in lieu of two meals, \$160.

The state hospital system has had experience with this outside residence of a small proportion of employees for over

three years. In the main, it has been satisfactory to all concerned. Certainly most of the fears at the outset have not been realized.

The future of the outside maintenance policy would seem to be quite clearly indicated. It allows the individual a more normal mode of life, which is particularly important to those who are married and have families. It tends to assist in the abolition of the pre-existing isolation of the hospital from the community, and it can with careful expansion in the future decrease expenditure for construction. Likewise by this same method it seems likely that present unsuitable quarters and crowding may be eliminated. However, it must be clearly recognized that a certain per cent of employees should probably reside on the institution grounds in order that sufficient personnel may be available for emergencies such as fire. Likewise, the extension of an outside residence policy for employees will probably not be so applicable to hospitals in rural sections where commutation facilities are limited as it will be to hospitals adjacent to large centers of population.

The Commission is of the opinion that a careful study of all phases of employee maintenance should be made by the Department of Mental Health in collaboration with the superintendents, giving full consideration to the conditions peculiar to each institution. Such a survey would seem properly to be the function of the present committee of superintendents on personnel and labor relations. Some standardization should probably be established regarding selected ranks and classes of employees whose residence on the grounds of the institutions seem desirable. Restrictions of this nature should be made along broad, general lines and should not be so rigidly drawn that further extension of outside maintenance policies could not be allowed where local conditions made this advisable. There appears common agreement to the thought that married employees in subordinate rank should be given preference for residence in the community.

Study of the suggestions that some employees' quarters may be converted to patients' use should be a part of this survey. Considerable argument for and against this proposal has been heard, and it is referred to more fully elsewhere in this report. Since this matter is, for the present, purely in the nature of an experiment, it is recommended that the plan should first be tried in only one or two instances where conditions are satisfactory and the administrators of the institution are favorably

inclined to the proposal. Probably the only class of patients who could safely be accommodated in this manner would be so-called "parole patients," those who have been granted privileges of the grounds and whose return to community life is anticipated.

Some thought has been given the wage-scale of employees. The opinion has been expressed that certain subordinate positions are underpaid. Superintendents state that it is their experience that in times of economic depression satisfactory personnel have readily been obtained, but during periods of general economic prosperity relatively large numbers of employees have left the service and it has been extremely difficult to replace them with individuals of the proper type. However, since this problem is interdepartmental, definite specific recommendations cannot be made. A salary schedule for the institutional service in the Department is presented for consideration:

Salary Schedule — Institutional Service.

TITLE.	Salary Range per Annum.
Assistant baker	\$720- \$900 ¹
Assistant cook	540- 720 ¹
Assistant dietitian	840- 1,080 ¹
Assistant herdman	720- 900 ¹
Assistant meatcutter	540- 720 ¹
Assistant pharmacist	840- 1,140 ¹
Assistant physician	1,800- 2,400 ¹
Assistant principal of school of nursing	1,440- 1,800 ¹
Assistant psychiatric social worker	1,020- 1,320 ¹
Assistant state hospital steward	1,440- 1,800 ¹
Assistant superintendent of State Hospital	3,300- 4,020 ¹
Attendant nurse	540- 840 ¹
Baker	1,140- 1,320 ¹
Barber	660- 900 ¹
Blacksmith	1,440- 1,740 ²
Carpenter	1,440- 1,740 ²
Carpenter foreman (working foreman)	1,740- 2,040 ²
Charge attendant nurse	840- 1,080 ¹
Chauffeur	960- 1,200 ¹
Chef	1,320- 1,560 ¹
Chief executive officer of Boston Psychopathic Hospital	3,600- 4,320 ¹

¹ With maintenance.

² Without maintenance.

Salary Schedule — Institutional Service — Continued.

TITLE.	Salary Range per Annum.
Chief hospital supervisor, attendant	\$1,440- \$1,800 ¹
Chief hospital supervisor, graduate nurse	1,620- 1,980 ¹
Chief medical officer of Boston Psychopathic Hospital	3,420- 4,140 ¹
Chief power plant engineer, Grade A	2,280- 2,640 ¹
Chief power plant engineer, Grade B	2,040- 2,400 ¹
Chief power plant engineer, Grade C	2,040- 2,400 ¹
Chief power plant engineer, Grade D	1,800- 2,160 ¹
Clinical assistant	540- 600 ¹
Clothing caretaker	780- 960 ¹
Construction handyman	1,320- 1,560 ²
Cook	720- 900 ¹
Dairyman	720- 900 ¹
Dental assistant	780- 1,080 ¹
Dentist	1,680- 2,160 ¹
Dietitian	1,320- 1,560 ¹
Dining room attendant	480- 660 ¹
Director of clinical psychiatry	3,300- 4,020 ¹
Dormitory matron for the feeble-minded	840- 1,080 ¹
Electrician	1,440- 1,740 ²
Electrician's helper	1,260- 1,500 ²
Farmer	1,020- 1,200 ¹
Farm Colony supervisor	1,320- 1,560 ¹
Farmhand	660- 840 ¹
First-class power plant engineer	2,040- 2,280 ²
Florist	900- 1,140 ¹
Garage foreman (working foreman)	1,380- 1,620 ¹
Groundskeeper	900- 1,140 ¹
Head cook	1,020- 1,200 ¹
Head dining room attendant	720- 900 ¹
Head farmer	1,440- 1,800 ¹
Head housekeeper	1,080- 1,320 ¹
Head industrial therapist	1,200- 1,560 ¹
Head laundryman	1,140- 1,320 ¹
Head nurse	1,080- 1,200 ¹
Head occupational therapist	1,200- 1,560 ¹
Head psychiatric nurse	960- 1,140 ¹
Head psychologist	2,280- 2,640 ¹
Head seamstress	720- 900 ¹

¹ With maintenance.² Without maintenance.

Salary Schedule — Institutional Service — Continued.

TITLE.	Salary Range per Annum.
Head social worker	\$1,800- \$2,160 ¹
Head teacher of institution school	1,440- 1,800 ¹
Head waiter	720- 900 ¹
Herdsmen	1,020- 1,200 ¹
Hospital recreation room caretaker	840- 1,080 ¹
Hospital supervisor, attendant	1,200- 1,380 ¹
Hospital supervisor, graduate nurse	1,320- 1,560 ¹
Hospital usher	660- 900 ¹
Housekeeper	540- 780 ¹
Housemaid	480- 660 ¹
Hydrotherapist	1,080- 1,320 ¹
Industrial therapist	840- 1,140 ¹
Institution porter	540- 720 ¹
Institution school teacher	900- 1,320 ¹
Institution stableman	840- 1,020 ¹
Institution teamster	660- 900 ¹
Institution treasurer	1,560- 1,920 ¹
Interne	300 ¹
Interne, Boston Psychopathic Hospital	900 ¹
Junior boys' industrial instructor	780- 1,080 ¹
Junior chemist	1,320- 1,800 ¹
Junior clerk (includes junior clerk and typist)	540- 900 ¹
Junior clerk and stenographer	540- 900 ¹
Kitchen helper	480- 660 ¹
Laboratory assistant	780- 1,080 ¹
Laboratory technician	840- 1,140 ¹
Launderer	720- 900 ¹
Laundry worker	480- 660 ¹
Library reference assistant	1,560- 1,920 ¹
Machinist	1,500- 1,740 ²
Maintenance foreman of State Hospital	2,160- 2,520 ²
Mason	1,440- 1,740 ²
Meat cutter	900- 1,140 ¹
Mechanical handyman	1,320- 1,560 ²
Medical director, Boston Psychopathic Hospital (part time)	3,000 ²
Motor equipment repairman	1,020- 1,320 ¹
Motor truck driver	960- 1,200 ¹
Occupational therapist	780- 1,080 ¹

¹ With maintenance.² Without maintenance.

Salary Schedule — Institutional Service — Concluded.

TITLE.	Salary Range per Annum.
Painter	\$1,320- \$1,560 ²
Painter foreman (working foreman)	1,440- 1,740 ²
Pharmacist	1,200- 1,440 ¹
Physiotherapist	1,080- 1,320 ¹
Plumber and steamfitter	1,440- 1,740 ²
Poultryman	900- 1,140 ¹
Power plant helper	1,260- 1,440 ²
Principal clerk	1,440- 1,800 ¹
Principal of school of nursing	2,040- 2,400 ¹
Psychiatric graduate nurse	780- 900 ¹
Psychiatric social worker	1,320- 1,800 ¹
Psychologist	1,320- 1,800 ¹
Psychometrist	780- 1,080 ¹
Seamstress	540- 720 ¹
Second-class power plant engineer	1,920- 2,160 ²
Senior boys' industrial instructor	1,080- 1,440 ¹
Senior clerk	960- 1,320 ¹
Senior clerk and typist	960- 1,320 ¹
Senior clerk and stenographer	960- 1,320 ¹
Senior library assistant	1,140- 1,500 ¹
Senior physician	2,520- 3,060 ¹
Special attendant, State Hospital	840- 1,080 ¹
State hospital steward	2,280- 2,640 ¹
Steam fireman	1,440- 1,800 ²
Storekeeper	1,080- 1,440 ¹
Storeroom helper	780- 1,080 ¹
Student nurse	540- 780 ¹
Superintendent of State Hospital	4,500- 5,700 ¹
Supervising institution housekeeper	840- 1,020 ¹
Swineherd	900- 1,140 ¹
Third-class power plant engineer	1,680- 1,920 ²
Tinsmith	1,380- 1,680 ²
Tractor driver	960- 1,200 ¹
Vegetable gardener	900- 1,140 ¹
Waiter	480- 660 ¹
Watchman	660- 1,020 ¹
Working foreman	1,740 ²
X-ray technician	840- 1,140 ¹

¹ With maintenance.² Without maintenance.

One phase of this question of remuneration concerns money allowed in lieu of maintenance. Practically all subordinate positions are salaried with the understanding that the institution shall provide maintenance. Maintenance for such positions consists of one room, meals and laundry. The maximum extra compensation allowed for those who have been placed outside has been \$280 per year (\$120 in lieu of room; \$160 in lieu of two meals). In other words, under such circumstances the employee is allowed \$5.36 per week with which to provide lodging and two meals a day, the third meal being received at the Hospital.

The relationship of physician and ward personnel quotas to patient population has been reviewed. The following table presents the actual quotas allotted each institution as of December 1, 1938:

TABLE 2. — *Personnel Quotas.*¹

INSTITUTION.	Medical. ²	WARD SERVICE. ³		
		Male.	Female.	Total.
<i>Hospitals.</i>				
Psychopathic	21	28	27	55
Boston State	18	204	260	464
Danvers	15	160	184	344
Foxborough	11	85	100	185
Gardner	10	107	78	185
Grafton	10	106	106	212
Medfield	11	115	163	278
Metropolitan	10	131	127	258
Northampton	12	127	163	290
Taunton	13	126	136	262
Westborough	12	107	120	227
Worcester	17	177	203	380
Monson	9	129	126	255
<i>Schools.</i>				
Belchertown	7	71	95	166
W. E. Fernald	11	170	123	293
Wrentham	11	125	135	260

¹ Data obtained from Department of Mental Health records.

² Includes one dentist at each institution.

³ Composed of those having direct supervision of patients: attendants, supervisors, nurses of all grades, hydrotherapists, etc.

The ratios of these quotas to the expected patient population in the institutions are shown in the following table:

TABLE 3. — *Ratios, Personnel per 100 Patients, 1939.*

INSTITUTION.	Medical.	WARD SERVICE. ¹			Patient Quota × 100. ²
		Male.	Female.	Total.	
<i>Hospitals.</i>					
Psychopathic	23.3	31.1	30.0	61.1	.90
Boston State . . . . .	.7	8.3	10.6	19.0	24.40
Danvers . . . . .	.6	6.8	7.8	14.7	23.40
Foxborough . . . . .	.7	6.0	7.1	13.2	14.00
Gardner . . . . .	.6	7.3	5.3	12.6	14.60
Grafton . . . . .	.6	6.7	6.7	13.5	15.70
Medfield . . . . .	.5	6.1	8.7	14.9	18.65
Metropolitan . . . . .	.5	6.7	6.5	13.2	19.50
Northampton . . . . .	.5	6.2	8.0	14.2	20.30
Taunton . . . . .	.7	7.3	7.8	15.1	17.25
Westborough . . . . .	.7	6.7	7.6	14.4	15.75
Worcester . . . . .	.6	7.2	8.2	15.5	24.50
Average, 11 hospitals . . . .	.6	6.8	7.7	14.6	-
Monson . . . . .	.5	8.4	8.2	16.6	15.35
<i>Schools.</i>					
Belchertown . . . . .	.5	5.2	7.0	12.2	13.50
W. E. Fernald . . . . .	.5	8.9	6.4	15.4	19.00
Wrentham . . . . .	.5	6.4	6.9	13.4	19.40
Average, three schools . . . .	.5	6.8	6.7	13.7	-

¹ Based on 1938's quota positions.

² Based on 1939's patient quotas, i.e., estimated patient population.

In studying medical personnel ratios, one notes .6 per 100 patients as an average for 11 state hospitals. Expressed in other terms, this represents approximately 1 medical officer per 166 patients, a very favorable proportion. In evaluating these figures, however, it must be realized that not all of the medical officers of a given hospital spend the major part of their time dealing with patients in the practice of psychiatry. Included in each hospital's medical quota is the dentist and the superintendent. In most instances it also includes a school clinic

physician, whose time on the wards is minimal. In some institutions there is a pathologist who likewise is not available for regular ward duty. Each of these is contributing his part to the patients' welfare by very necessary and worth-while duties, but no one of them is regularly available for the day by day practice of psychiatry with the individual patient. The inclusion of these positions in quotas from which ratios are derived is perhaps proper but should be understood. When adjustment is made for such positions, the ratios are more real and less favorable. In any determination of medical quota it must be remembered that the foundation of psychiatric success, as in any branch of medicine, is the careful clinical study of the individual patient by the physician.

The ward personnel ratios in the main show fair standardization of employee allotments to the institutions. It is not obvious why one hospital should require 19.0 employees on ward service per 100 patients and another require only 12.6 employees. The Department is understood to have prepared similar comparative tables for all classifications of its employees. Such tables will serve as basic guides in adjusting employee quotas in the interest of efficiency, economy and proper utilization of salary funds. It is expected that such basic data will be supplemented by detailed information made available by the newly created Division of State Hospital Inspection.

The utilization of such a scheme of control demands not only a careful study of individual hospital conditions, but also requires rather strict adherence to classification and duty assignments of employees. The superintendent should review his institution's pay roll to ascertain that each employee is actually performing duties within his classification. Where this is not the case, steps should be taken to reassign the position in proper classification. Only when classification is adhered to will ratios present a true picture for each hospital.

In connection with this we wish to make reference to our belief (see page 204, Appendix 9, "Problem of Maintenance") that transfers from the personal services item should be few and far between, and only when completely justified. It has come to our attention that there have been vacancies in various classifications for, in some cases, considerable periods of time. We believe that a superintendent or board of trustees should have a reasonable period in which to select staff and employee personnel, but we feel that this period should be

limited to a month. Usually when a medical man is about to leave he gives the hospital authorities advance notice, and, with the additional 30 days, it seems to us that a properly qualified successor could be chosen.

If the money allotted for personal services is used up by keeping of quotas filled, in conformity with the desire of the Legislature that patients in the mental institutions be given proper care, there will be no incentive for transferring to other less important items.

APPENDIX 13.

PROBLEM OF THE EPILEPSIES.

The care, treatment and study of epilepsy within the Massachusetts state hospital system is provided chiefly at the Monson State Hospital, whose patient population is restricted to those suffering from convulsive disorders. The following table indicates the distribution of epileptics in the state hospitals and schools. A study of this table shows that 75.3 per cent of epileptics in institutions whose figures were available are cared for at Monson State Hospital. It is also evident that the patient population of Monson consists roughly of one third psychotic (insane) patients and two thirds non-psychotic (sane) individuals. Elsewhere in the state hospitals there is no significant number of epileptics in any single institution, except at Grafton. The epileptic population there in residence has accumulated chiefly by transfer of psychotic patients from Monson to relieve crowding in the latter institution.

The foregoing statements make it clear that the practice to date has been to allocate epileptics chiefly to one hospital, allowing a relatively small overflow to collect in a second institution. While there may be some doubt regarding the necessity of segregation of insane adult epileptics from other types of insane patients, there is no question of the desirability of such practice for the sane and childhood groups. In the case of these adults, their handling within a large psychotic group presents a considerable administrative problem. The deteriorated, physically incapacitated, demand a large amount of infirmity-type care. Epileptic children should be segregated because of the psychic trauma to the non-convulsive of similar age. Likewise, school and recreational facilities must be furnished, intermingling with adult patients discouraged, and appropriate housing must be provided with adequate nursing service for infants and the ill or incapacitated.

The problem of epileptic segregation necessitates a scrutiny of the present housing situation. The average number under care at Monson during 1938 was 1,481 patients.¹ On many occasions the population was of course in excess of this figure.²

The rated capacity of the hospital was 1,177 patients;¹ 1938's average census was, therefore, 304 in excess of this figure, or 25.8 per cent.

Admission and discharge rates show the expected slow accumulation in resident population.

TABLE 1. — *Known Epileptics in Residence in Institutions, September 30, 1937.*³

INSTITUTION.	With Psychosis.	Without Psychosis.
<i>Hospitals.</i>		
Psychopathic	1	—
Boston State	42	—
Danvers	35	—
Foxborough	22	—
Gardner	5	—
Grafton	144	—
Medfield	33	—
Metropolitan	3	—
Monson	558	957
Northampton	18	—
Taunton	25	—
Westborough	28	—
Worcester	16	—
<i>Schools.</i>		
Belchertown	—	33
W. E. Fernald	—	55
Wrentham	—	35
Other institutions	49	3
Totals	979	1,083

¹ For fiscal year ending November 30, 1938. From Department of Mental Health monthly census and capacity tables.

² For instance, as of November 1, 1938, there were 1,564 patients actually in residence.

³ Data derived from the annual reports of the institutions and from the annual report of the Commissioner.

TABLE 2. — *Admissions and Discharges, Monson State Hospital, 1933-37, inclusive.*¹

FOR THE YEAR ENDING NOVEMBER 30 —	Total Admissions.	Discharges, Exclusive of Transfers.	Resident Population, Increase.
1933	224	191	33
1934	202	197	5
1935	226	179	47
1936	190	164	26
1937	198	161	37
Totals	1,040	892	148

Even in spite of this admission rate, the hospital has a waiting list of 179² desiring care and treatment. Furthermore, there is a relatively small but constant influx of epileptics into the unrestricted state hospitals each year.

To meet this situation, the logical step appears to be additional construction at the Monson State Hospital. There has been recommended to the Commission by the superintendent in a letter of February 25, 1938, the broad outline for the building up of this hospital to approximately 2,000 patients. In essence this plan suggests:

1. Buildings on male side of hospital:

- (a) A male infirmary for 160 patients.
- (b) A ward building to accommodate 160 patients.
- (c) A building for deteriorated boys requiring special care — 100 patients.

2. Buildings on female side of hospital:

- (a) Ward building for 160 patients.
- (b) A building for deteriorated girls requiring special care — 100 patients.
- (c) A building to house 100 children under six years of age, divided equally between boys and girls.

Such a program would, of course, necessitate some additions to the services of supply throughout the hospital and possibly additional quarters for personnel.

Any proposal to continue the relative concentration of epileptics at Monson has a direct bearing upon research. The

¹ Data taken from "The Annual Report of the Commissioner of Mental Diseases" for the respective years.

² As of January 1, 1939. Personal communication from superintendent of Monson State Hospital.

whole problem of the epilepsies is far from solution, despite discovery of new methods of study during recent years. Outstanding research contributions have been forthcoming from Monson over the past thirty years, and research remains a vital interest. The hospital has at present co-operative contacts with outstanding Boston neurologists for investigative programs. These and other contacts should be fostered and extended in such a center of epileptic population.

Any attempt to study the whole problem of the epilepsies soon reveals that available data are incomplete. The figures grouped in Table 1 for "Other institutions" do not include many of the private institutions and schools. There are no accurate statistics available regarding non-institutionalized cases. Thought should be given to a central registry for epileptics such as exists for mental defectives at the present time.

APPENDIX 14.

PROBLEM OF PSYCHOTIC ADULTS.

OVERCROWDING.

In the State of Massachusetts approximately 75 per cent of the insane are cared for in public hospitals. The statutes provide for the care and supervision of these people through the Department of Mental Health. There are thirteen institutions solely for the care of this group in the State of Massachusetts. Many years ago, when the State took over this responsibility, institutions were built to adequately care for the insane as the laws prohibited their detention in jails and almshouses. In that period they were known as asylums and gave largely custodial care.

Today, however, the function of these institutions is vastly different, and they are in fact modern hospitals for the mentally ill. This change has been brought about by the tremendous research of the last quarter century in the problem of insanity, stressing largely the nature and treatment of these conditions. Formerly there was a definite stigma attached on being an inmate of an asylum, but, due to an enlightened public and a better understanding by the medical profession of mental illness, this has decreased to a great extent.

Hospital care is now recognized as being absolutely essential in the treatment of these conditions, and therefore the population of the hospital has had a steady increase for a number of years.

Additions to these institutions in the form of new buildings in some instances, and remodeling in others, have not provided sufficient space to give adequate care to all desiring treatment. There exists, therefore, today an overcrowding in our institutions amounting to approximately 18 per cent.

To give an example of the steady increase in the population of the state hospitals, reference is made to Table 1. which shows the increase in number from 1904 to 1937; also the annual increase for each year. It is to be noted that there is approximately an average increase of 416 patients yearly, which affords an index of the number of extra beds to be provided for annually.

TABLE 1. — *Increase in Population in State Hospitals, 1904-37.*

YEAR.	STATE HOSPITALS.		
	Number.	Annual Increase.	Rate per 100,000.
1904	9,666	897	319.0
1905	10,071	405	326.4
1906	10,237	166	325.8
1907	10,602	365	331.5
1908	11,460	858	352.2
1909	11,994	534	362.3
1910	12,562	568	373.2
1911	12,972	410	379.9
1912	13,481	509	389.2
1913	13,862	381	394.7
1914	14,202	340	398.9
1915	14,657	455	406.1
1916	15,054	397	411.5
1917	15,434	380	416.4
1918	15,476	42	412.1
1919	15,409	-67	405.1
1920	15,686	277	407.2
1921	16,428	742	422.1
1922	16,810	382	427.5
1923	17,051	241	429.3
1924	17,515	464	436.6
1925	17,990	475	444.1
1926	18,149	159	443.7
1927	18,597	448	450.2
1928	18,997	400	455.6
1929	19,391	394	460.6
1930	19,848	457	467.1
1931	20,446	598	476.7
1932	20,856	410	481.8
1933	21,218	362	485.7
1934	21,579	361	489.5
1935	22,033	454	506.3
1936	22,576	543	516.4
1937	22,915	339	521.8
Average (34 years)	-	416	-

It is needless to say that overcrowding tends to irritation, accidents and attempts at violence which can be prevented by sufficient space.

To further show the tendency of overcrowding, Tables 2 and 3 give a comparison of a ten-year interval of 1928 and 1938.

TABLE 2. — *Capacity and Overcrowding of Mental Hospitals, December 1, 1938.*

INSTITUTION.	Capacity.	Patients in Institution.	OVERCROWDING.	
			Number.	Per Cent.
Psychopathic	109	71	38 ¹	34.86 ¹
Boston State	2,116	2,360	244	11.53
Danvers	1,861	2,325	464	24.93
Foxborough	1,134	1,430	296	26.10
Gardner	1,186	1,430	244	20.57
Grafton	1,258	1,543	285	22.66
Medfield	1,553	1,824	271	17.45
Metropolitan	1,589	1,875	286	17.99
Monson	1,177	1,545	368	31.27
Northampton	1,729	2,037	308	17.81
Taunton	1,285	1,699	414	32.22
Westborough	1,334	1,611	277	20.76
Worcester	2,385	2,346	39 ¹	1.64 ¹
Total	18,716	22,096	3,380	18.06

¹ Number under working capacity, no overcrowding.

TABLE 3. — *Capacity and Overcrowding of Mental Hospitals, October 1, 1928.*

INSTITUTION.	Capacity.	Patients in Institution.	OVERCROWDING.	
			Number.	Per Cent.
Psychopathic	126	86	40 ¹	31.74 ¹
Boston State	1,897	2,266	369	19.45
Danvers	1,684	1,925	241	14.31
Foxborough	905	957	52	5.74
Gardner	1,032	1,097	65	6.29
Grafton	1,152	1,555	403	34.98
Medfield	1,544	1,790	246	15.92
Monson	967	1,214	247	25.54
Northampton	1,565	1,304	261 ¹	31.74 ¹
Taunton	1,204	1,463	259	21.51
Westborough	1,221	1,390	169	13.84
Worcester	2,152	2,222	70	2.91
Total	17,030	18,997	1,967	11.55

¹ Number under working capacity, no overcrowding.

These tables give the capacity, number of patients in the institution and per cent of overcrowding by hospitals. It is interesting to note that in 1928 overcrowding of 11.55 per cent existed in the twelve institutions. In spite of the addition of a new hospital (Metropolitan State Hospital, 1930) of 1,589 beds, the overcrowding has increased to 18.06 per cent in 1938. It is evident, therefore, that the State must provide additional facilities for proper care. This should include both ward and service buildings.

TYPES OF MENTAL ILLNESS.

Of all the mental diseases, dementia præcox heads the list in frequency in our state institutions. For many years every effort has been made to learn the nature and treatment of this condition but without much success. Only recently a treatment known as shock therapy by medicine (insulin or metrazol) has given any encouragement in this respect.

In Table 4 it is to be noted that of the 13,524 patients who were in residence for the first time, 48.5 per cent are suffering

from dementia præcox; of the 9,512 who have had more than one admission to a hospital, 56.3 per cent were dementia præcox. From the above one can see that this disease constitutes more than 50 per cent of the resident population of the hospitals.

TABLE 4. — *Percentage of Mental Disorders in Residence, September 30, 1937.*

MENTAL DISORDERS.	FIRST ADMISSIONS.				READMISSIONS.			
	M.	F.	T.	Per Cent.	M.	F.	T.	Per Cent.
With syphilitic meningo-encephalitis.	402	118	520	3.8	155	46	201	2.1
With other forms of syphilis .	61	25	86	.6	23	8	31	.3
With epidemic encephalitis .	30	20	50	.4	32	13	45	.5
With other infectious diseases .	6	7	13	.1	—	2	2	.02
Alcoholic psychoses	746	122	868	6.4	384	76	460	4.8
Due to drugs, etc.	7	6	13	.1	5	3	8	.1
Traumatic psychoses	38	8	46	.3	25	2	27	.3
With cerebral arteriosclerosis .	532	524	1,056	7.7	96	114	210	2.2
With other disturbances of circulation.	11	13	24	.2	4	4	8	.1
With convulsive disorders (epilepsy).	264	293	557	4.1	230	192	422	4.4
Senile psychoses	182	352	534	3.9	30	48	78	.8
Involuntional psychoses . . .	120	270	390	2.9	46	119	165	1.7
Due to other metabolic diseases, etc.	33	46	79	.6	6	16	22	.2
Due to new growth	1	1	2	.01	2	2	4	.04
With organic changes of nervous system.	91	56	147	1.1	44	26	70	.7
Psychoneuroses	43	59	102	.7	39	42	81	.8
Manic-depressive psychoses . .	315	567	882	6.5	417	680	1,097	11.5
Dementia præcox	3,231	3,385	6,616	48.5	2,684	2,695	5,379	56.3
Paranoia and paranoid conditions.	142	281	423	3.1	74	161	235	2.5
With psychopathic personality .	51	47	98	.7	60	57	117	1.2
With mental deficiency	535	473	1,008	7.4	405	436	841	8.8
Undiagnosed psychoses	6	4	10	.1	7	2	9	.1
Without psychoses	66	29	95	.7	29	19	48	.5
Primary behavior disorders . .	4	2	6	.04	3	—	3	.03
Total with mental disorder .	6,847	6,677	13,524	99.3	4,768	4,744	9,512	99.5
Total without mental disorder.	70	31	101	.7	32	19	51	.5
Grand total	6,917	6,708	13,625	100.0	4,800	4,763	9,563	100.0

The manic-depressive psychosis is characterized by a high readmission rate. The more rapid relapses occur the longer the tendency is for the period of hospitalization to become.

Other types of illnesses which show rather high incidence in the first and readmissions in the resident population are the psychoses with mental deficiency.

TABLE 5. — *First Admission by Mental Disorders during 1937.*

MENTAL DISORDERS.	Number.	Per Cent.
With syphilitic meningo-encephalitis	167	3.4
With other forms of syphilis	19	.4
With epidemic encephalitis	7	.1
With other infectious diseases	23	.5
Alcoholic psychoses	453	9.1
Due to drugs, etc.	32	.6
Traumatic psychoses	24	.5
With cerebral arteriosclerosis	853	17.1
With other disturbances of circulation	56	1.1
With convulsive disorders (epilepsy)	96	1.9
Senile psychoses	302	6.1
Involitional psychoses	146	2.9
Due to other metabolic diseases, etc.	72	1.4
Due to new growth	10	.2
With organic changes of nervous system	85	1.7
Psychoneuroses	266	5.3
Manic-depressive psychoses	471	9.4
Dementia præcox	746	15.0
Paranoia and paranoid conditions	107	2.1
With psychopathic personality	58	1.2
With mental deficiency	103	2.1
Undiagnosed psychoses	94	1.9
Without psychoses	643	12.9
Primary behavior disorders	152	3.0
Total with mental disorder	4,190	84.1
Total without mental disorder	795	15.9
Grand total	4,985	100.0

TABLE 6. — *First Admission by Mental Illness during 1928.*

PSYCHOSES.	Male.	Female.	Total.	Per Cent.
Traumatic	13	2	15	.4
Senile	126	191	317	10.0
Cerebral arteriosclerosis	236	160	396	12.7
General paralysis	158	44	202	6.5
Cerebral syphilis	15	7	22	.7
Huntington's chorea	1	3	4	.1
With brain tumor	2	2	4	.1
With other brain or nervous diseases	37	26	63	2.0
Alcoholic	179	32	211	6.7
Due to drugs and other exogenous toxins	6	2	8	.2
With pellagra	—	2	2	.6
With other somatic diseases	34	67	101	3.2
Manic-depressive	141	246	387	12.4
Involution melancholia	22	61	83	2.6
Dementia præcox	332	295	627	20.1
Paranoia or paranoid conditions	38	39	77	2.4
Epileptic psychoses	32	26	58	2.8
Psychoneuroses and neuroses	15	18	33	1.0
With psychopathic personality	12	12	24	.7
With mental deficiency	44	39	83	2.6
Undiagnosed psychoses	161	157	318	10.1
Without psychoses	39	41	80	2.5
Total	1,643	1,472	3,115	100.0

Table 5 shows the number and percentage of first admissions by illness during the year 1937 and has no relation to the resident population.

The Commission wishes to call attention to one particular group of mental disorders that has increased materially during the last ten years.

In comparing Tables 5 and 6 it will be noted that a group known as psychosis with cerebral arteriosclerosis has increased from 12.7 per cent in 1928 to 17.1 per cent in 1937. This rise no doubt should effect the nature of a building program to be instituted, as it is particularly significant that an increased number of persons of the old-age group are being admitted to our hospitals, and these cases require a different classification and should be confined in either an infirmary or hospital

unit. The institutions at the present time do not have sufficient facilities for the proper care of this increasing group.

BOARDING-OUT PATIENTS.

What can be done to help relieve some of the overcrowding?

By boarding out, or family care, is meant the placing of patients who no longer require full, daily hospital supervision in selected families in the community, in order that they may benefit by the environment of family life rather than remain in an institutional atmosphere. This plan has been in vogue in Belgium and Scotland for many years, where it is used extensively. Some 3,000 patients are in family care in Belgium.

In 1885 the State Board of Charities established by legislation the boarding out of patients in private families. Until 1915 they remained under the supervision of this Department, when the control was transferred to the individual state hospitals.

The home in which the patient is placed becomes an integral part of the hospital. The patients are visited by a physician and social workers at stated intervals to determine the effect of such care on the patient, and also to look into his physical and mental needs at the time. If the patient fails to adjust in his new environment he is returned to the hospital and his place is taken by another suitable patient. The homes are carefully selected and inspected to determine the fitness of the family to take boarding-out patients. There results thereby a very close co-operation between the home and the hospital.

Certain questions may well be asked: Would the patients be exploited and overworked, would they receive proper food, and are they well cared for?

These questions are perfectly natural. However, those who have had experience tell us that more often the reason given by the family for desiring boarding-out patients is the presence of unused rooms in the home. Careful selection of the home and family is of first importance, and the best results are obtained by careful and repeated supervision by the hospital after the patient is placed.

Table 7 gives the number of patients placed in family care since 1904, and it is estimated that between 450 to 500 patients will have been placed by 1940.

TABLE 7. — *Patients in Family Care from Institutions and Under the Department of All State Hospitals, September 30, 1904-38.*

YEAR.	FAMILY CARE, GRAND TOTAL.			FROM INSTITUTIONS.			UNDER THE DEPARTMENT.		
	M.	F.	T.	M.	F.	T.	M.	F.	T.
1904	14	199	213	-	-	-	14	199	213
1905	13	243	256	1	2	3	12	241	253
1906	13	282	295	-	10	10	13	272	285
1907	13	270	283	-	8	8	13	262	275
1908	12	238	250	1	5	6	11	233	244
1909	10	239	249	-	8	8	10	231	241
1910	16	269	285	2	8	10	14	261	275
1911	15	294	309	1	10	11	14	284	298
1912	15	327	342	2	24	26	13	303	316
1913	14	352	366	2	28	30	12	324	336
1914	21	320	341	9	30	39	12	290	302
1915	28	375	403	27	290	317	1	85	86
1916	35	363	398	35	299	334	-	64	64
1917	29	296	325	29	249	278	-	47	47
1918	23	263	286	23	219	242	-	44	44
1919	27	228	255	27	190	217	-	38	38
1920	15	201	216	15	167	182	-	34	34
1921	10	185	195	10	154	164	-	31	31
1922	12	187	199	12	158	170	-	29	29
1923	9	159	168	9	132	141	-	27	27
1924	4	152	156	4	132	136	-	20	20
1925	10	154	164	10	131	141	-	23	23
1926	8	149	157	8	127	135	-	22	22
1927	14	156	170	14	136	150	-	20	20
1928	28	128	156	28	109	137	-	19	19
1929	23	147	170	23	130	153	-	17	17
1930	23	146	169	23	132	155	-	14	14
1931	19	173	192	19	151	170	-	22	22
1932	24	184	208	24	171	195	-	13	13
1933	34	231	265	34	217	251	-	14	14
1934	35	242	277	35	242	277	-	-	-
1935	38	273	311	38	273	311	-	-	-
1936	48	275	323	48	275	323	-	-	-
1937	63	273	336	63	273	336	-	-	-
1938	64	258	322	64	258	322	-	-	-

Family care affords an opportunity for the patient to do things that he likes, to enjoy the outdoors and the sharing of home life. It is natural to expect that the individual would be happier in home surroundings rather than confined with large numbers in a hospital. Furthermore, economically it represents a distinct saving to the Commonwealth. The average cost per week for each patient in family care amounts to approximately \$7. This includes board, \$4.50, as stipulated by statute (section 16, chapter 123 of the General Laws), clothing, and medical supervision furnished in most cases by the hospital. In the hospital the same care would cost \$8.25. Thus there is a saving of about \$36,000 per year for every 100 patients boarded out. To this must be added the saving on the capital investment of \$200,000 that would be necessary to provide accommodations for the same number if they were to remain in a hospital. If the boarding-out program of 450 to 500 patients by 1940 is realized as planned by the Department of Mental Health, a saving of approximately \$2,000,000 on capital investment will be made.

The Commission therefore recommends that —

1. The boarding-out program be increased as much as possible.
2. In view of economic conditions the weekly rate paid for board be raised from \$4.50, but shall not exceed \$6 per week. Legislation to this end is contained in Appendix 10.

OLD-AGE ASSISTANCE.

Another method of reducing the cost and also the number of patients in the hospitals is through the use of the Old Age Assistance Act, for those who are eligible.

The economic condition of the relatives of some of the patients is frequently such that they cannot take on the extra burden of supporting another individual without added financial help, yet there are a number of patients who are well enough to be tried out on visit if they could avail themselves of this aid. At the present time a patient must be completely discharged before old-age assistance will be granted. If provision were made whereby the patient on visit could receive aid, a greater number, no doubt, would leave the hospital at an earlier date.

CENTRALIZATION OF SPECIAL CASES — TUBERCULAR AND MATERNITY.

Tubercular Cases.

It is well known that tuberculosis frequently is a complication of dementia præcox. This is largely due to the sedentary habits of these cases, their unwillingness to co-operate in their care, and refusal to indulge in proper voluntary exercise. In an apparently healthy person tuberculosis often develops insidiously. The annual physical examinations at the hospital frequently bring out symptoms of this disease, and further diagnostic tests are made to confirm the findings. New admissions who are tubercular also add to the list.

The facilities for caring for tubercular cases in this State are inadequate. Only a few hospitals have separate buildings of fireproof construction for this group, the remainder having either frame-shell type of pavilion which is now outmoded, or separate wards of small capacity. These wards are not equipped to care for the disturbed tubercular patient who must remain on the regular disturbed ward in a room, thereby being a potential menace to the other patients in this ward. In October, 1937, there were 589 known tubercular cases in residence in the hospitals.

Centralization of these cases in buildings or groups of buildings of sufficient size and located at certain of the institutions so as to serve all parts of the State is recommended as a means of solving this problem. There should be at least four units, located in the western, central, northeastern and southeastern portions of the State.

Maternity Cases.

Although the incidence of mental illness developing in maternity cases is not excessive, sufficient numbers are admitted yearly to give consideration to this problem. Aside from the Worcester State Hospital, where there is a small unit exclusive for maternity cases and a nursery, adequate facilities are not at hand for proper prenatal to after-delivery care in our hospitals. At least two such units should be maintained totally apart from the others, to which maternity cases may be admitted or transferred from other hospitals. These units should be located to serve the state hospital from a geographic point of view.

The Commission recommends —

1. For tubercular patients, that four units of sufficient size be established and so located in certain of the institutions as to serve all sections of the State.

2. For maternity cases, that one additional maternity unit be established to afford proper maternity care for the eastern portion of the State.

BUILDING PROGRAM.

General Consideration.

Many of the hospitals of the State constructed years ago were of stone or brick exteriors and wood interiors. In some instances frame buildings were built in a cottage-type plan of hospital. This is particularly true of some of the buildings at the Grafton State Hospital. This type of construction is not fireproof and also is expensive to remodel and maintain. Furthermore, utilization of all the space is frequently impossible in order to properly classify patients to their best advantage. As before mentioned, there is an increase in the number of patients of advanced years in residence, and with the present economic uncertainty this type of patient will probably continue to show an increase. These cases require infirmary and frequently medical and surgical care. Adequate facilities for this type of treatment are not available in many of the hospitals, which leads to overcrowding of this group.

In order that newly admitted patients entering the hospital for the first time receive every advantage, separate units or acute receiving buildings should be maintained. Frequently many of these cases recover in a few months and require no further hospitalization. It is not good treatment to have these cases mixed with those of the continued treatment type, where less active therapy is required.

In accordance with modern medical trends our hospitals should afford every advantage to the physically ill patient. To do this, adequate hospital units should be maintained in order to give proper surgical and medical attention to these conditions. All of the hospitals have infirmary wards where this type of work is now being done, and frequently under much handicap. Few of the hospitals have proper isolation facilities for infectious cases, so that when they do occur, in order to prevent contagion, entire wards must be vacated.

Size of Hospital.

The ideal size of an institution that can be operated efficiently is thought to be 2,000 beds. Referring to Table 8, under date of December 1, 1938, excluding the Boston Psychopathic Hospital, which has but 109 beds, 12 hospitals give care to 22,025 patients (column 6). Yet only two of the hospitals have a working capacity of over 2,000 (column 3). The others range from 1,134 to 1,861. In the last column it is to be noted that four of the hospitals have to date an average number under care of over 2,000 patients, and the other eight hospitals vary from 1,376 to 1,861, respectively.

TABLE 8. — *Working Capacity and Patients Actually in Residence, December 1, 1938.*

INSTITUTIONS.	WORKING CAPACITY.			IN INSTITUTION EXCLUSIVE OF PATIENTS BOARDED IN FAMILIES.			Average Number under Care to Date.
	M.	F.	T.	M.	F.	T.	
	1	2	3	4	5	6	7
Psychopathic	60	49	109	38	33	71	74
Boston State	1,004	1,112	2,116	1,029	1,331	2,360	2,411
Danvers	870	991	1,861	1,082	1,243	2,325	2,339
Foxborough	543	591	1,134	663	767	1,430	1,376
Gardner	712	474	1,186	831	599	1,430	1,531
Grafton	646	612	1,258	777	765	1,543	1,498
Medfield	638	915	1,553	752	1,072	1,824	1,861
Metropolitan	813	776	1,589	859	1,016	1,875	1,821
Monson	511	666	1,177	729	816	1,545	1,533
Northampton	730	999	1,729	937	1,100	2,037	2,013
Taunton	623	662	1,285	843	856	1,699	1,690
Westborough	546	788	1,334	688	923	1,611	1,571
Worcester	1,252	1,133	2,385	1,149	1,197	2,346	2,463
Totals	8,948	9,768	18,716	10,377	11,719	22,096	22,181

Unless the saturation point has been reached, which is doubtful, the eight hospitals which are less than 2,000 capacity should be enlarged to this figure. This would give approximately 24,000 beds at the end of a building program continued over a period of years.

Types of Hospitals.

In this country three types of hospitals have been built in the past, and each has been modified to meet the needs of a particular type of institution.

The Kirkbride plan consists of a central administration building in which all administrative functions are carried out. From this building to either side are wings ending in cross sections, which give accommodations to lavatories, bath-rooms, etc. Continuing on from these cross sections, other wings were added and could be extended to very distant points. This frequently brought about a much spread-out institution. This allowed for the classification of the quieter group near the administration building, while the disturbed patients were in the more distant wings.

One disadvantage was that with the further addition of wings the patients residing in the last wing were too distant to receive proper medical attention. In this State a number of hospitals were built on a modified Kirkbride plan, among these being the Danvers and Worcester State Hospitals.

To meet the disadvantages of the Kirkbride plan a block system became in vogue in some hospitals. In this type a series of block buildings were constructed about a central administration building. This likewise has some disadvantages, mainly insufficient fresh air and sunlight.

The ideal type is the cottage plan. Here separate buildings are constructed and equipped to give proper classification. These closely surround a central administration building, and in close proximity to this building are the acute receiving units and hospital buildings. At a distance are buildings for the more disturbed and continued treatment cases.

In the course of the investigation the Commission visited all of the institutions as well as a number in the neighboring States. In one State buildings of nine or more stories were constructed with porches for outdoor activities. Yet sufficient land area was available. Many of the patients confined for long periods had no opportunity to set foot on land for years, and their only opportunity for fresh air and exercise was confined to the porch. In another State one-story buildings were constructed with ample recreation grounds surrounding the buildings, affording, in our opinion, the ideal plan. Recreation could be carried out both winter and summer, and we believe this to be an important part of therapy.

Since the establishment of the forty-eight-hour law, money in lieu of maintenance was given to employees for whom there were no quarters available. No dissatisfaction has occurred. On the contrary, many employees prefer to live with their families. Consideration might well be given to extend this plan to all employees except those who, it is felt, should remain at the institution for emergencies. This would make available in some institutions buildings that could be converted at a minimum expense into patients' quarters. Furthermore, the capital investment on more employees' buildings would also be saved.

The Commission recommends —

1. That a building program be promulgated to furnish sufficient bed space to care for the excess number in the hospitals and to further expansion.
2. That units be established for the care of the tubercular, acute reception building, medical and surgical units with isolation departments.
3. That the study to determine the type of hospital that would best suit the needs of the Commonwealth be continued by the Department.

APPENDIX 15.

PROBLEM OF NARCOTIC ADDICTS.

Under section 62, chapter 123 of the General Laws, "Any of the judges named in section fifty, or a judge of the municipal court of the city of Boston, may commit to the state farm, or to any other institution under the department of correction that may be designated by the governor, to the McLean hospital, or to a private licensed institution, by an order of commitment, directed to the trustees, superintendent, or manager thereof, as the case may be, made in accordance with section fifty-one, and accompanied by a certificate, in accordance with section fifty-three, by two physicians qualified as therein provided, any male or female person, who is subject to dipsomania or inebriety either in public or private, or who is so addicted to the intemperate use of narcotics or stimulants as to have lost the power of self-control."

In other words, although the problem of drug addiction is considered to be pre-eminently a medical problem, yet the State at the present time furnishes no facilities for treatment for drug addiction except in institutions under the jurisdiction of the Department of Correction. This Commission feels that emphasis should be placed on the medical nature of the problem; that psychological factors are of vital importance; and that the problem properly comes under the jurisdiction of the Department of Mental Health.

This Commission wishes to call attention to the report of the special commission on drug addiction authorized by chapter 36 of the Resolves of 1930 and published in December, 1930.

As a result of its investigation and researches the aforementioned Commission offered as its first recommendation "that fifty beds should be set aside in one of the hospitals of the Department of Mental Diseases or in a new ward added to one of these hospitals, for the treatment of and experimentation with drug addiction, its causes, effect, nature and cure."

While this Commission has not had the opportunity of thoroughly studying the problem of narcotic addiction in Massachusetts, it is convinced that a serious problem does exist. Accurate data on the incidence of narcotic addiction are extremely difficult to obtain. It was primarily for this reason that the commission on drug addiction recommended a small experimental unit of fifty beds "until more definite information as to its need and usefulness were established."

Since 1930 there has been reported, both in the lay and medical press, an increase in drug addiction through the use of a drug called "marihuana." This weed is easily grown and obtained without too great difficulty. The problem of drug addiction is thus increased.

This Commission likewise believes that there exists in many cases a fundamental psychological derangement as a basis for the development and continuation of the drug habit.

Hospitalization should be for both males and females.

Inasmuch as this Commission is in accord with certain suggestions of the commission on drug addiction, we wish to repeat those suggestions for purposes of emphasis:

(a) Treatment and care should be free only if the patient is unable to pay.

(b) The type of treatment should be left entirely to the discretion of the physician in charge, with the approval of the Department having jurisdiction over the hospital.

(c) Voluntary patients should be required to submit to the rules of the institution, both as to duration of stay and as to required periodic reports for examination after discharge.

(d) Voluntary patients who have violated the rules of the institution as to duration of stay or after-care should be readmitted only on commitment as outlined in the next paragraph.

(e) Involuntary patients should be committed in the manner provided for the commitment of the insane, of dipsomaniacs, or of drug addicts in the manner prescribed by sections 51, 52, 53, 62, 63 and 86 of chapter 123 of the General Laws of Massachusetts, as amended by chapter 535 of the Acts of 1922, sections 4, 5 and 6; and the Acts of 1922, chapter 535, section 4, must be amended to include the name of the institution for drug addicts and the name of the Department having jurisdiction over such institution.

(f) Involuntary commitments should be limited to a period not exceeding two years, and enforced after-care should be limited to a period of three years after original commitment to the institution.

(g) No patient, voluntary or committed, should be discharged within three months after the date of commitment.

(h) A social service department should be established in connection with the institution, with an adequate number of workers to follow up all discharged cases.

Further, the institution when constructed should have adequate general and psychological laboratory facilities, including personnel.

As the Special Commission has been unable to give thorough study to this very difficult subject, no specific recommendation is made.

APPENDIX 16.

PROBLEM OF ALCOHOLIC ADDICTS.

What has been said of drug addiction concerning facilities for treatment applies equally to alcoholism. The report of the special commission on the advisability of establishing public clinics, etc., for treatment of persons of confirmed habits of intoxication, December 4, 1935, points out that "the principal disadvantage of the present provision for the civil commitment of inebriates is that even though the commitment is civil it must be made to a penal institution, — namely, the State Farm in the case of men, and the Reformatory for Women in the case of women. An additional handicap exists in the fact that although a criminal commitment for drunkenness to the State Farm calls for a maximum of one year, a civil commitment to the same institution by reason of inebriety provides for a maximum of two years."

The same report commented that "it would be entirely logical for the General Court to authorize the care of the inebriates by the Department of Mental Diseases, as was the case prior to 1922."

The necessity for keeping such patients separate from the insane is obvious. It seems equally obvious that they should be kept separate from criminals. It has been pointed out that there has been some reluctance on the part of the courts to make use of the existing provisions of civil commitment.

The potential importance of the problem of alcoholism may be emphasized by a comparison of the first admissions of patients suffering from alcoholic psychoses and the incidence of first admissions classified as intemperate in the use of alcohol for the year 1920, the first year of the Eighteenth Amendment, and from 1933, the first year of repeal, to the present time.

YEAR.	Total First Ad- missions, All Diagnoses.	Alcoholic First Ad- missions, Alcoholic Psychoses.	Psychoses, Per Cent First Ad- missions.	Number In- temperate, All First Ad- missions.	Per Cent First Ad- missions.
1920	3,279	126	3.8	461	14.0
1933	4,554	332	7.2	884	19.4
1934	4,549	395	8.6	981	21.5
1935	4,816	428	8.8	1,113	23.1
1936	5,035	451	8.9	1,242	24.6
1937	4,985	453	9.0	1,269	25.4
1938	4,980	461	9.2	1,325	26.6

There is a slow, steady increase in hospitalization, due to the alcoholic psychoses. Of perhaps greater importance is the high percentage of first admissions to the hospitals classified as intemperate in the use of alcohol. Since 1933 there has also been a gradual increase in the number of patients recorded as intemperate. When alcohol is used to excess it exerts a poisonous effect on the brain cells. It is entirely possible that in many mentally ill patients over-indulgence in alcohol is the "straw that breaks the camel's back" and actually precipitates latent psychoses. It is, of course, true that alcoholism itself may be only a symptom of mental disorder.

The outcome of alcoholic psychoses is rather good for early cases; in other words, they are fairly amenable to treatment. The average length of time of residence in hospitals of first admissions discharged as recovered in 1937 was 0.68 year; as improved, 0.50 year; and as unimproved, 1.37 years. During the year 376 patients suffering from alcoholic psychoses were discharged: 174, or 46.2 per cent, as recovered; 192, or 51 per cent, as improved; and 10, or 2.6 per cent, as unimproved; 453 patients were admitted in 1937 with alcoholic psychoses. The death rate in this group is relatively low; 65 deaths occurred during the year in this grouping.

Alcoholic psychoses can be prevented by abstinence from alcohol. The disease is preventable. Social factors play a significant rôle in the development of the alcoholic habit. Often it represents a withdrawal from reality, an escape from the hard facts of life.

There are, roughly, ninety to a hundred thousand arrests each year for drunkenness in Massachusetts. Many of these

arrests are made on chronic drinkers. Is it time to enact legislation that repeated arrests for drunkenness will result in mandatory admission to a hospital for inebriates for periods of not less than three months? This is about the shortest time required to do anything constructive from a medico-social point of view. The costs of repeated arrests and occasional incarceration in correctional institutions, and perhaps the incidence of hospitalization for frank alcoholic and even other psychoses in which alcoholism may be a precipitating factor, might be reduced by such measures.

The important point from the taxpayers' point of view is whether the incidence of admissions to hospitals can be reduced. From the medical viewpoint prevention of the alcoholic psychoses is vitally important. The proverbial "ounce of prevention is worth a pound of cure" is particularly appropriate in this connection.

Again, the State did take cognizance of alcoholism as a mental problem when the Foxborough State Hospital was opened in 1893 as a hospital for inebriates, who were required to be of good character and repute apart from habits of inebriety. It was known as the Massachusetts Hospital for Dipsomaniacs and Inebriates. The law provided that the persons committed thereto could be held for a period of two years, although the trustees were empowered to parole them at liberty during that time under such limitations as they deemed best.

The hospital was not designed for strictly custodial cases, and the trustees made appeals for more careful discrimination in the selection of patients sent for treatment.

In 1905 the name of this hospital was changed to the Foxborough Hospital, and a ward was set apart for mental patients. The trustees reported in 1910 that the hospital at Foxborough was intended for young and hopeful cases, and that the hospital was handicapped in that it was not equipped for the various types of inebriates committed thereto. They recommended sufficient land for agricultural development, a sufficient plant for industrial training and workshops, and also for segregation.

Accordingly, land was purchased for a new hospital at Norfolk and a colony established there. For a time this was operated as a branch of the Foxborough Hospital, but eventually it was made a separate institution known as the Norfolk State Hospital in 1914. The hospital at Norfolk continued to operate until it was closed as a result of prohibition in 1919.

In 1922 provision was made to care for male and female inebriates at the State Farm in Bridgewater under the Department of Correction, but all those who wished treatment in private hospitals continued to be received at the private hospitals licensed under this Department. The women inebriates since 1933 have been sent to the Reformatory for Women.

At the present time facilities for such preventive measures are not available in the Massachusetts state hospitals, and until the General Court is ready to make such facilities available no mandatory legislation making problems of inebriety a responsibility of the Department of Mental Health should be enacted.

APPENDIX 17.

PROBLEM OF THE BOSTON PSYCHOPATHIC HOSPITAL.

THE PURPOSE OF THE HOSPITAL.

The Boston Psychopathic Hospital was created by an act of the Legislature in 1909. It was to be operated in conjunction with the Boston State Hospital, as its psychopathic department, although the building was located at 74 Fenwood Road.

The purpose of the hospital was —

1. To give care and examination, hospitalization and study of all classes of mental patients.
2. To provide for short intensive treatment of the incipient, acute and curable mental diseases.
3. To provide facilities for scientific investigation with a view to prevention and cure of mental disease.
4. To give clinical instruction to medical students, the medical profession and particularly the family physician, in order that they would be better able to recognize mental disease in its early stages.
5. To be an educational center for associated workers, — nurses, social workers and other specialized groups.
6. To afford free consultation for the poor and to aid in the home care of mental patients.

The term “psychopathic” has been used in connection with many other activities besides the true Psychopathic Hospital, such as psychopathic wards and units.

The true Psychopathic Hospital is an institution for the reception of doubtful and difficult cases for study, in contrast to the state hospital which receives, largely, court committed cases for long and continued treatment. The Psychopathic Hospital is not to be thought of as a haven for the purely committed case.

In the second annual report of the psychopathic department of the Boston State Hospital in 1913, statistics show that there were 1,391 non-court cases admitted during the year;

and of these, 726, or more than 50 per cent, were eventually committed to other state hospitals as insane. It is further stated that the other 665 patients were spared the stigma of court commitment. The report further indicated that with the establishment of a Psychopathic Hospital in the community as a resort for the mentally-ill individual, there would occur an increase in the financial burden of the State. The maintenance cost of the Psychopathic Department is buried in the general maintenance figures of the Boston State Hospital, so that a comparative figure for the per capita cost for the years 1912-20 is not available.

In 1920 the Psychopathic Department withdrew from the Boston State Hospital and became a separate unit, having its own board of trustees and separate appropriations.

In the first annual report of the newly organized Psychopathic Hospital in 1920, it is stated that the hospital has become a clearing house for the disposal of a large number of patients. It was the feeling at the time that the length of stay in the hospital was limited to only ten days. However, it was felt that if the hospital were to undertake the treatment of curable cases, as well as the study of the nature of the causes of insanity, the hospital should be prepared to care for patients for longer periods; that is, weeks and months.

The appropriation for that year was \$204,442, and with a daily average population of 93 patients it represented a weekly per capita cost of \$41.91. This high figure was due to the relatively small number of patients in residence. At that time there were 112 officers and employees, of which 15 were physicians.

In 1930, after a ten-year interval, appropriations had increased to \$248,856.79, or an increase of 21.6 per cent. There was, however, little change in the daily average population, which was 86.40 for the year. The per capita cost for this year amounted to \$55.39, and shows an increase of \$13.48. At the same time, the personnel had increased from 112 to 141 in number. The increase in cost was largely attributed to the increased personnel, which at this time represented nearly two thirds of the total appropriation.

In 1937, the last report available, the total appropriation had increased to \$255,600 — again without showing any material increase in the number of patients cared for. The gross per capita weekly cost for this year was \$63.88, and the personnel had again showed an increase to 157.

GENERAL COMMENT.

The Boston Psychopathic Hospital has essentially two directors, a medical director and a chief executive officer, both charged with the responsibility of administering the affairs of the hospital. It is essentially a dual control, and must lead to difficulty.

The medical director is a part-time physician, and cares largely for the general supervision of the patients; teaching; the out-patient and research departments.

The chief executive officer cares for the routine business of the hospital, purchasing supplies, and generally looks after the welfare of the institution. Through his department, commitments of patients are made to other hospitals, as are hospital discharges.

At the present time there are 18 physicians assigned to the staff. Of these, 11 care for patients in the house, 3 are occupied with the out-patient department, 2 are in X-ray and laboratory work, and 2 are in the executive department.

With the large number of patients admitted yearly, it is evident that the work-up of the cases must be brief, and frequently it is necessary to form an opinion of the patient's mental condition in six or seven days, in order to effect the patient's commitment to another hospital before the expiration of his temporary care period. The end result, then, is the resemblance to a clearing house, as previously mentioned.

Much of the work is duplicated if the patient is committed to one of the larger state hospitals, where a complete new work-up of the case is again made without reference to any extent to the records of the Boston Psychopathic Hospital. It would seem, therefore, that these same cases could be admitted directly to other hospitals and commitment recommended from there just as well as from the Boston Psychopathic Hospital. Furthermore, the per capita cost is decidedly less in a larger institution, averaging from \$7 to \$8 per week, in contrast to the present per capita cost of the Boston Psychopathic Hospital, which is \$63.88. It is true that considerable benefit is given to various social agencies by the out-patient department of the hospital. During the year ending September 30, 1937, 736 new patients were seen and advised in this department. There are three physicians and one social worker assigned to care for this work; other personnel, such as psychologists and stenographers, are drawn from the general hospital staff.

WHAT TO DO WITH THE BOSTON PSYCHOPATHIC HOSPITAL.

From the above figures it can be noted that the per capita cost has increased from \$41.91 to \$63.88, or \$21.97 in 17 years. Yet there has been no gross change in either the bed capacity or the number of patients received yearly. It would, therefore, appear advisable that a study be made to justify further need of this hospital.

The Commission has several thoughts on the matter presented to it:

1. Complete abolition of the Boston Psychopathic Hospital as such, with a transfer of the several associated departments — as the out-patient department and clinic for venereal disease — to some other city hospital center. The mental patients to be admitted directly to the several state hospitals serving the eastern portion of the State; or, instead, the establishment of a psychiatric service in the general hospitals serving the city of Boston. The Commonwealth could well afford to reimburse the various hospitals for the maintenance of such patients at a much lower figure than is now being spent for the same care at the Boston Psychopathic Hospital. It would still afford teaching material for the medical schools in Massachusetts.

2. The present building might well serve as an office building for several of the state departments. This could be accomplished at a minimum of expense. One might think of the building as a center for the state medical activities, namely, for the Department of Mental Health, the Department of Public Health and state laboratories.

The annual expense of maintaining the building would be relatively small, and it would likewise reduce the necessity of constructing further public buildings to house some of the departments which have outgrown their present quarters.

3. As an alternative — the preservation of the past accomplishments of the Boston Psychopathic Hospital and the reduction of expenditures; a reorganization might well be considered.

The bed capacity could be increased to perhaps 200.

As many patients as possible could be kept for continued hospitalization; particularly, those recommended 35-day court observations. Regular commitments could be made to other hospitals, as has been done in the past.

The medical personnel could be drawn from the general state hospital group for a period of study in psychiatry and

modern treatment of mental disease. This would afford a well-trained personnel for the outlying state hospital group.

It is interesting to note in this respect that very few of the physicians trained at the Boston Psychopathic Hospital have remained in the state hospital system.

With an increase in patients under care, and a reduction of cost of medical personnel, the annual appropriation could be materially reduced in comparison with the amount of work done.

The following table gives a comparison of the total number of patients received, the daily average number in the hospital, by year, the ratio of patients to ward employees and to total employees, the weekly per capita cost, and the yearly appropriations:

Boston Psychopathic Hospital — General Medical Statistics.

YEAR.	Admissions.	Average Number of Patients in Residence.	Ward Personnel.	Ratio of Patients to Ward Employees.	Total Number of Employees.	Ratio of Patients to Total Personnel.	Weekly per Capita Cost.	General Appropriation, Yearly Total.
1921 . .	1,964	93.82	45	2.0	112	.839	\$39 90	\$198,885
1922 . .	2,006	91.80	47	2.0	120	.76	39 03	213,674
1923 . .	1,862	78.91	48	1.6	135	.58	45 57	211,158
1924 . .	1,839	85.92	48	1.9	138	.62	43 89	220,010
1925 . .	1,716	85.57	48	1.7	140	.61	44 34	221,550
1926 . .	1,602	84.31	48	1.7	138	.61	49 64	224,900
1927 . .	1,747	85.08	53	1.6	143	.6	46 90	232,350
1928 . .	1,906	87.93	49	1.7	140	.628	48 52	248,579
1929 . .	1,870	79.27	50	1.6	146	.54	56 12	254,700
1930 . .	1,882	86.40	46	1.9	141	.61	51 91	255,850
1931 . .	1,914	83.80	48	1.7	121	.5	52 90	253,100
1932 . .	1,948	79.81	49	1.6	144	.55	53 33	235,450
1933 . .	2,019	73.90	48	1.5	143	.51	52 63	209,287
1934 . .	2,000	73.20	48	1.5	145	.50	52 96	212,930
1935 . .	1,935	80.43	55	1.4	153	.52	54 64	234,897
1936 . .	2,089	81.34	56	1.4	151	.54	57 24	244,360
1937 . .	2,121	73.93	56	1.3	151	.49	61 65	255,600

APPENDIX 18.

CAPACITY AND POPULATION OF INSTITUTIONS.

Table showing Detail of Capacity and Population of Institutions, January 1, 1939.

INSTITUTIONS.	WORKING CAPACITY, 1938.			Whole Num- ber Under Care.	IN INSTITUTION EXCLUSIVE OF PATIENTS BOARDED IN FAMILIES.				EXCESS OF PATIENTS.						AVERAGE NUMBER —			Under Care to Date.		
	M.	F.	T.		NUMBER.				PER CENT.						IN INSTITUTION.					
											Esti- mated, 1939.	To Date.	Per Cent of Ex- cess.							
<i>Hospitals.</i>																				
Psychopathic	60	49	109	74	49	25	74	11 ¹	24 ¹	35 ¹	18 33 ¹	48 98 ¹	32 11 ¹	90	64	28 89 ¹	64			
Boston State	1,004	1,112	2,116	2,301	997	1,302	2,299	7 ¹	190	183	0 70 ¹	17 09	8 47	2,440	2,313	5 20 ¹	2,315			
Danvers	870	991	1,861	2,312	1,076	1,228	2,304	206	237	443	23 68	23 92	23 81	2,340	2,302	1 62 ¹	2,310			
Foxborough	543	591	1,134	1,431	661	765	1,426	118	174	292	21 73	29 44	25 75	1,400	1,423	1 64	1,430			
Gardner	712	474	1,186	1,539	824	600	1,424	112	126	238	15 73	26 58	20 07	1,460	1,427	2 26 ¹	1,543			
Grafton	646	612	1,258	1,548	774	761	1,535	128	149	277	19 81	24 35	22 02	1,570	1,538	2 04 ¹	1,552			
Medfield	638	915	1,553	1,819	750	1,063	1,813	112	148	260	17 55	16 17	16 74	1,865	1,813	2 79 ¹	1,819			
Metropolitan	813	776	1,589	1,853	845	1,001	1,846	32	225	257	3 94	28 99	16 17	1,950	1,854	4 92 ¹	1,861			
Monson	511	666	1,177	1,451	684	767	1,451	173	101	274	33 86	15 17	23 28	1,535	1,481	3 51 ¹	1,481			
Northampton	730	999	1,729	2,045	938	1,083	2,021	208	84	292	28 49	8 41	16 89	2,030	2,019	.54 ¹	2,042			
Taunton	623	662	1,285	1,661	826	833	1,659	203	171	374	32 58	25 83	29 11	1,725	1,669	3 25 ¹	1,672			
Westborough	546	788	1,334	1,592	663	901	1,564	117	113	230	21 43	14 34	17 24	1,575	1,583	.51	1,611			
Worcester	1,252	1,133	2,385	2,466	1,153	1,196	2,349	99 ¹	63	36 ¹	7 91 ¹	5 56	1 51 ¹	2,450	2,347	4 20 ¹	2,463			
Total	8,948	9,768	18,716	22,092	10,240	11,525	21,765	1,292	1,757	3,049	14 44	17 99	16 29	22,430	21,833	2 66 ¹	22,163			

1 Decrease.

¹ Decrease.

Table showing Detail of Capacity and Population of Institutions, January 1, 1939 — Concluded.

INSTITUTIONS.	WORKING CAPACITY, 1938.			Whole Num- ber Under Care.			IN INSTITUTION EXCLUSIVE OF PATIENTS BOARDED IN FAMILIES.						EXCESS OF PATIENTS.						AVERAGE NUMBER —			Under Care to Date.
													NUMBER.			PER CENT.			IN INSTITUTION.			
	M.	F.	T.	M.	F.	T.	M.	F.	T.	M.	F.	T.	Esti- mated, 1939.	To Date.	Per Cent of Ex- cess.							
<i>Hospitals.</i>																						
Bridgewater	908	-	908	888	-	888	20 ¹	-	20 ¹	2.20 ¹	-	2.20 ¹	910	889	2.31 ¹	889						
Mental wards, Tewks- bury.	107	496	603	464	387	464	30 ¹	109 ¹	139 ¹	28.04 ¹	21.98 ¹	23.05 ¹	490	465	5.10 ¹	465						
Total	1,015	496	1,511	1,352	387	1,352	50 ¹	109 ¹	159 ¹	4.93 ¹	21.98 ¹	10.52 ¹	1,400	1,354	3.29 ¹	1,354						
Grand totals	9,963	10,264	20,227	23,444	11,912	23,117	1,242	1,648	2,890	12.47	16.06	14.29	23,830	23,187	2.70 ¹	23,517						
<i>Schools.</i>																						
Belchertown	440	662	1,102	1,306	748	1,306	118	86	204	26.82	12.99	18.51	1,320	1,301	1.21 ¹	1,326						
W. E. Fernald	906	634	1,540	1,972	807	1,972	259	173	432	28.59	27.29	28.05	1,900	1,972	3.79	1,972						
Wrentham	637	724	1,361	2,001	1,137	2,001	227	413	640	35.64	57.04	47.02	1,940	1,998	2.99	1,998						
Total	1,983	2,020	4,003	5,279	2,692	5,279	604	672	1,276	30.46	33.27	31.88	5,160	5,274	2.21	5,296						
Aggregates	11,946	12,284	24,230	28,723	14,604	28,396	1,846	2,320	4,166	15.45	18.89	17.19	28,990	28,461	1.82 ¹	28,813						

¹ Decrease.

APPENDIX 19.

LIST OF COMMITTEES ASSIGNED BY THE COMMISSION.

I. RELATION BETWEEN DEPARTMENT AND HOSPITAL:

Dr. Morgan B. Hodskins, Monson State Hospital.
Dr. C. Stanley Raymond, Wrentham State School.
Dr. Ralph M. Chambers, Taunton State Hospital.

II. DELINQUENT AND PSYCHOTIC CHILDREN:

Dr. Ransom A. Greene, Fernald State School.
Dr. Clarence A. Bonner, Danvers State Hospital.
Dr. Edwin S. Ward, Hospital Cottages for Children.

III. FOOD, CLOTHING, FURNITURE, etc.:

Dr. George E. McPherson, Belchertown State School.
Dr. W. Franklin Wood, McLean Hospital.
Dr. Harold F. Norton, Boston State Hospital.
Mr. Herbert Smith, Steward at Worcester State Hospital.

IV. HOSPITAL STANDARDS:

Dr. Roy D. Halloran, Metropolitan State Hospital.
Dr. William A. Bryan, Worcester State Hospital.
Dr. Walter E. Lang, Westborough State Hospital.

V. CONSTRUCTION:

Dr. A. Warren Stearns, Associate Commissioner, Department of Mental Diseases.
Dr. Arthur N. Ball, Northampton State Hospital.
Walter E. Boyd, Supervising Hospital Construction Engineer, Department of Mental Diseases.

VI. BOSTON PSYCHOPATHIC HOSPITAL:

Dr. A. Warren Stearns, Associate Commissioner.
Dr. Henry M. Pollock, Associate Commissioner.
Dr. Riley H. Guthrie, Psychopathic Hospital.
Dr. Douglas A. Thom, Department of Mental Diseases (Director of Division of Mental Hygiene).

VII. METHODS OF ADMISSION AND DISCHARGE:

Dr. George E. McPherson, Belchertown State School.
Dr. Earl K. Holt, Medfield State Hospital.
Dr. Roderick B. Dexter, Foxborough State Hospital.

VIII. RESEARCH CENTER AND METHODS:

- Dr. Douglas A. Thom, Department of Mental Diseases.
- Dr. Abraham Myerson.
- Dr. R. G. Hoskins, Director of Research at Worcester State Hospital.
- Dr. C. Macfie Campbell, Psychopathic Hospital.

IX. BRIDGEWATER AND TEWKSBURY:

- Dr. Laurence K. Kelley, State Infirmary.
- Dr. A. Warren Stearns, Associate Commissioner.
- Dr. Harlan L. Paine, Grafton State Hospital.

X. PRIVATE CARE OF PATIENTS AND HOUSING OF EMPLOYEES:

- Dr. Harlan L. Paine, Grafton State Hospital.
- Dr. Charles E. Thompson, Gardner State Hospital.
- Dr. Walter E. Lang, Westborough State Hospital.

APPENDIX 20.

INVESTIGATION OF SUDDEN DEATHS IN THE HOSPITALS.

An investigation of sudden deaths in mental hospitals was made by Eugene M. McSweeney, Commissioner of Public Safety, and Patrick J. Moynihan, chairman of the Commission on Administration and Finance. The following statement was released by the Governor's office on January 7, 1938:

Dr. Clifton T. Perkins, Acting Commissioner of Mental Diseases, in a report to Governor Charles F. Hurley containing an analysis of 232 so-called "sudden deaths" which occurred in 16 state hospitals and schools for mental defectives, together with the mental wards at Bridgewater and Tewksbury, declared:

It is true that the suicidal propensity among the mentally ill is far greater than among those of normal mentality, and the effect of suggestion through public comment has many times greatly indicated the urgency, from a medical point of view, in restraining publicity on this type of death.

The pointing out of ways and means for suggestible minds to complete their visualized self-sacrifice is far removed from the slightest trait of medical therapy.

The report covers the fiscal year December 1, 1936, to November 30, 1937, inclusive.

Dr. Perkins declared that each suicide was —

thoroughly investigated, and from time to time, at least during the past seven months, investigations have resulted in establishing definite policies relative to the administration of given hospitals.

Since there has been some question raised in the public press relative to drownings, I would point out that the only drowning was case No. 120, who was drowned in a body of water on the hospital grounds, and not in a tub within the hospital as had been implied.

It likewise will be noted that of the seven suicides from poisoning, six of these took that poison and were in critical condition prior to admission to the hospital, and the seventh case took poison at home some months after leaving the hospital.

Of the three suicides as a result of burning, one committed the act at home prior to admission to the hospital; a second committed the act with matches produced by a relative for smoking purposes; and the third committed the act through matches probably obtained from somewhere on the ward on which the patient resided.

In relation to so-called "sudden deaths," Dr. Perkins reported:

You will note that many of these deaths are accredited to fractures, and in this regard I would state that all patients who die within a year of a fracture, no matter how simple that fracture might be, are considered sudden deaths and are subject to the scrutiny of the medical examiner. In these cases the medical examiner generally accepts jurisdiction, occasionally he does not.

In studying the detail of this special group it cannot be overlooked that to a certain degree the relation of accidents or assaults on patients as noted above, are proportional to the numerical and intellectual amount of personnel available for supervision of patients, and likewise to the degree of overcrowding. It likewise cannot be overlooked that the physical make-up of patients is a large factor to be considered. Stout people in general do not break bones as readily as those of thin make-up. Elderly individuals might receive a relatively light blow which might result seriously. In our crowded state institutions, which among the hospitals (exclusive of the schools for the feeble-minded) run to as high as 31.5 per cent overcrowding, we cannot guarantee freedom from altercations.

From an analysis of deaths from alcoholism, it will be noted that *in all cases the acute alcoholism was acquired prior to hospital admission, was the immediate cause for hospital admission, and in no case did the patient live long after commitment.* In the larger cities in the Commonwealth acute alcoholic cases are usually cared for in special wards in the larger general hospitals, but in the smaller towns and outlying districts the acute alcoholics in the frenzy of delirium tremens, requiring immediate and expert medical attention, have as an outlet only admission to a state mental hospital.

I have commented somewhat on fractures above, but in studying the fractures further, as summarized, you will note that *eighteen occurred outside of the hospital*, and a breakdown of the analysis appears in the following summary. You will note particularly that there was *one death from fracture which was of a homicidal nature and constituted the only so-called "homicide" within the hospitals during the year 1937.*

The large number of sudden deaths, totaling 95, in which none of the above classifications played any part are due to sudden, unexpected developments during the natural course of disease process, but because of their suddenness were referred for special study to the Department, the State Pathologist, and, in most instances, the Medical Examiner.

Summarized Analysis of Cases of Suicides and Other Violent or Sudden Deaths reported to the Department of Mental Diseases by State Institutions under its Jurisdiction for Fiscal Year 1937.

Total cases reported	232
Suicides, including one questionable case which may have been accidental death and so recorded by medical examiner	24
Fatal act occurred prior to hospital admission	8
Fatal act occurred while on visit or escape	4
Fatal act occurred within hospital	12
Cases in which altercations between patients, impulsive actions of patients, or unprovoked assaults occurred in cases dying within one year (fractures sustained in eight of these cases)	11
Deaths from acute alcoholism or immediate effects of alcoholism	10
Time elapsing between hospital admission and death:	
Same day	2
One day	2
Within one week	4
Within three weeks	1
Within five weeks	1
Fractures which occurred any time within twelve months prior to death	79
Fractures occurred in hospital	61
Fractures occurred outside hospital	18
From accidental falls	57
Altercation between patients	6
Suicide	1
Impulsive act of patient	6
Homicide	1
Cause not determined	7
Patients with injuries which played no significant rôle in cause of death (accidental)	22
Sudden deaths in which alcoholism, fractures, suicides, homicides and injuries played no significant part	95
 Total	 241
 Number counted twice	 9
Suicide	1
Altercations and fractures	8
Corrected total	232

Add - Organizational Charts & Program
No. on waiting list - Provision for emergency
Some of laws.
V. Comm. Dept. of H. Repats.

Q's Mass Cong.

p. 29 - Complaint - function of B & Z Institute?



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